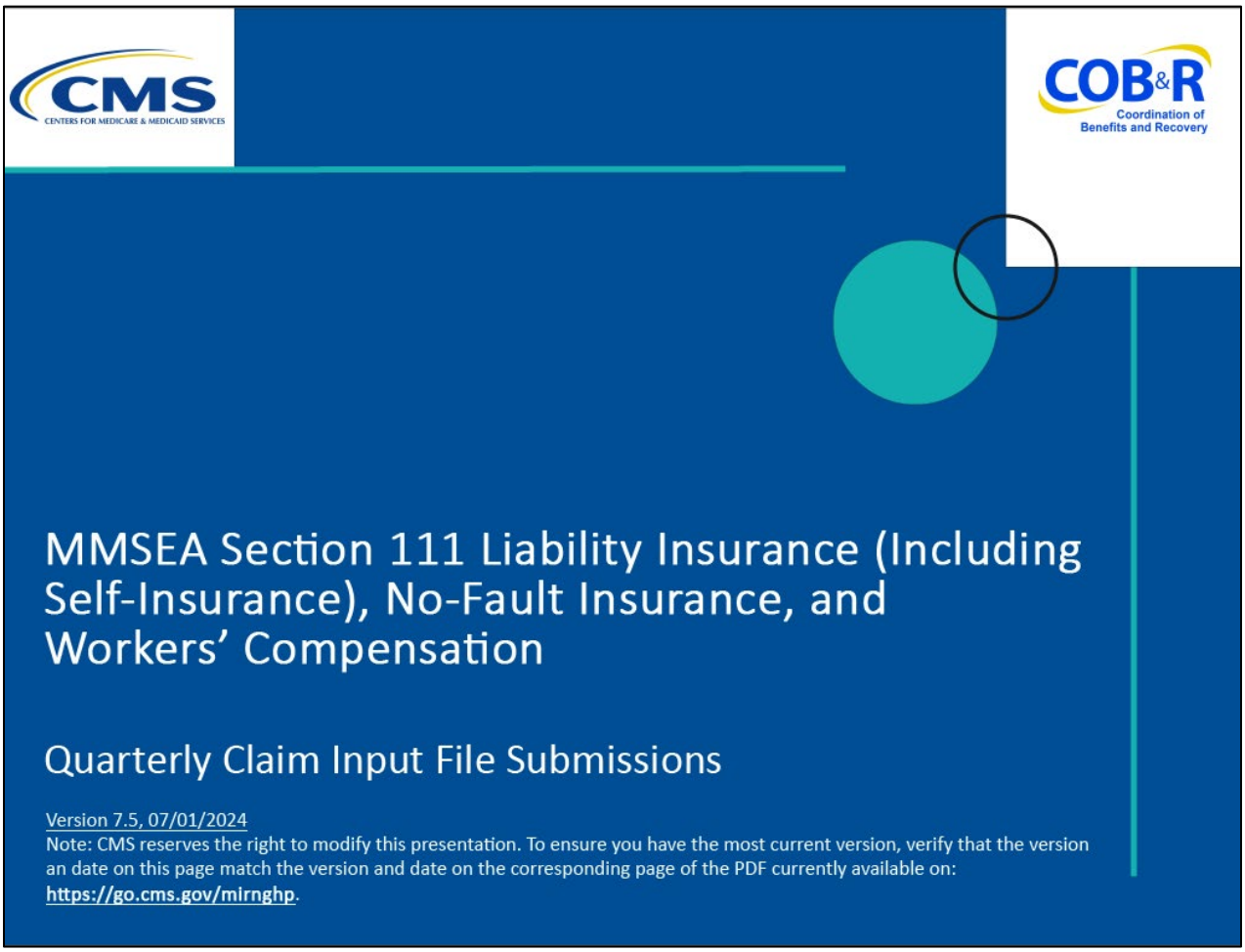
Quarterly Claim Input File Submission Introduction

Slide 1 of 38 - Quarterly Claim Input File Submission Introduction

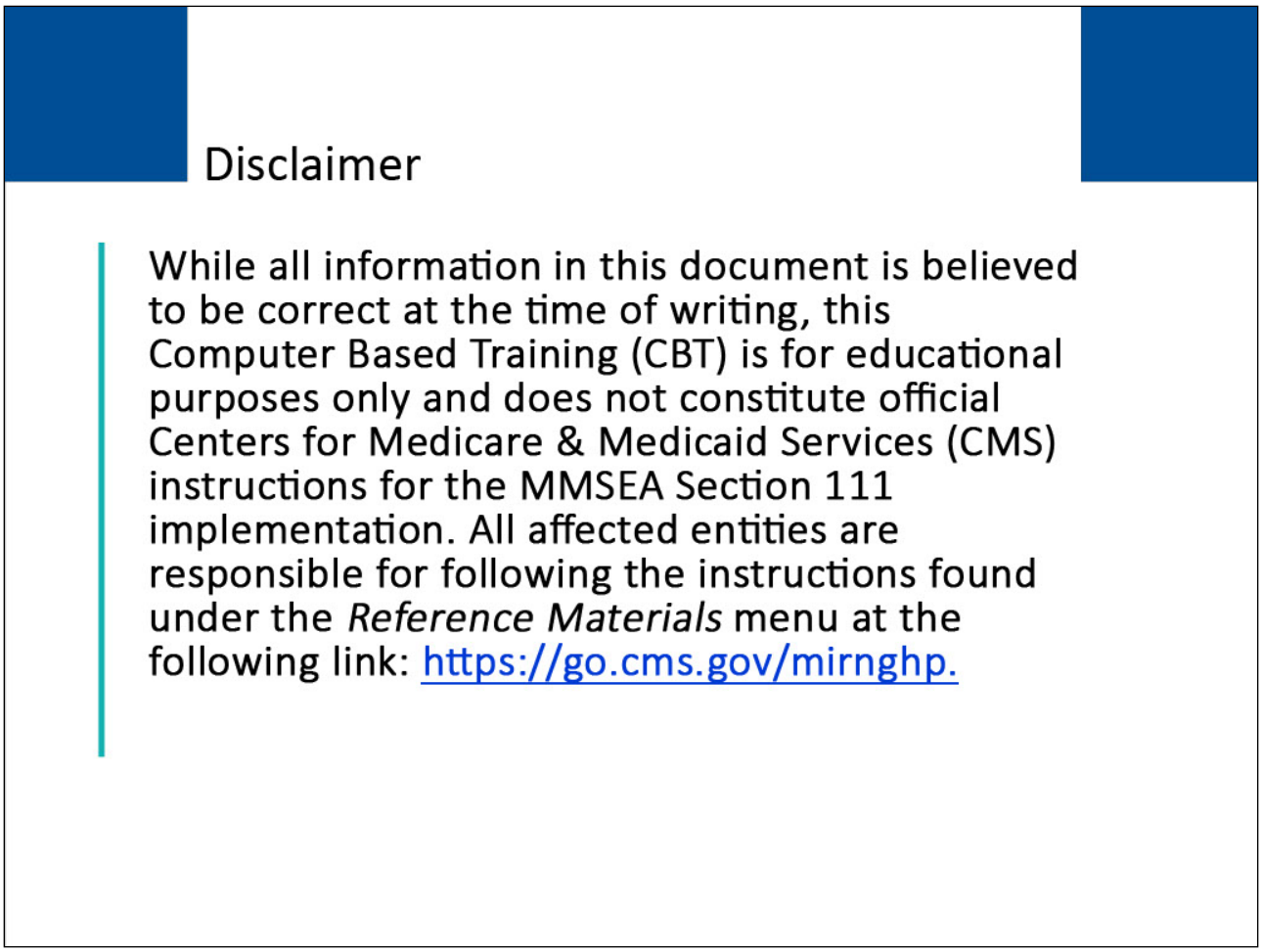


Slide notes

Welcome to the Quarterly Claim Input File Submission course.

Note: This module applies to Responsible Reporting Entities (RREs) that will be submitting Section 111 claim information via an electronic file submission as well as those RREs that will be submitting this information via Direct Data Entry (DDE).

Slide 2 of 38 - Disclaimer

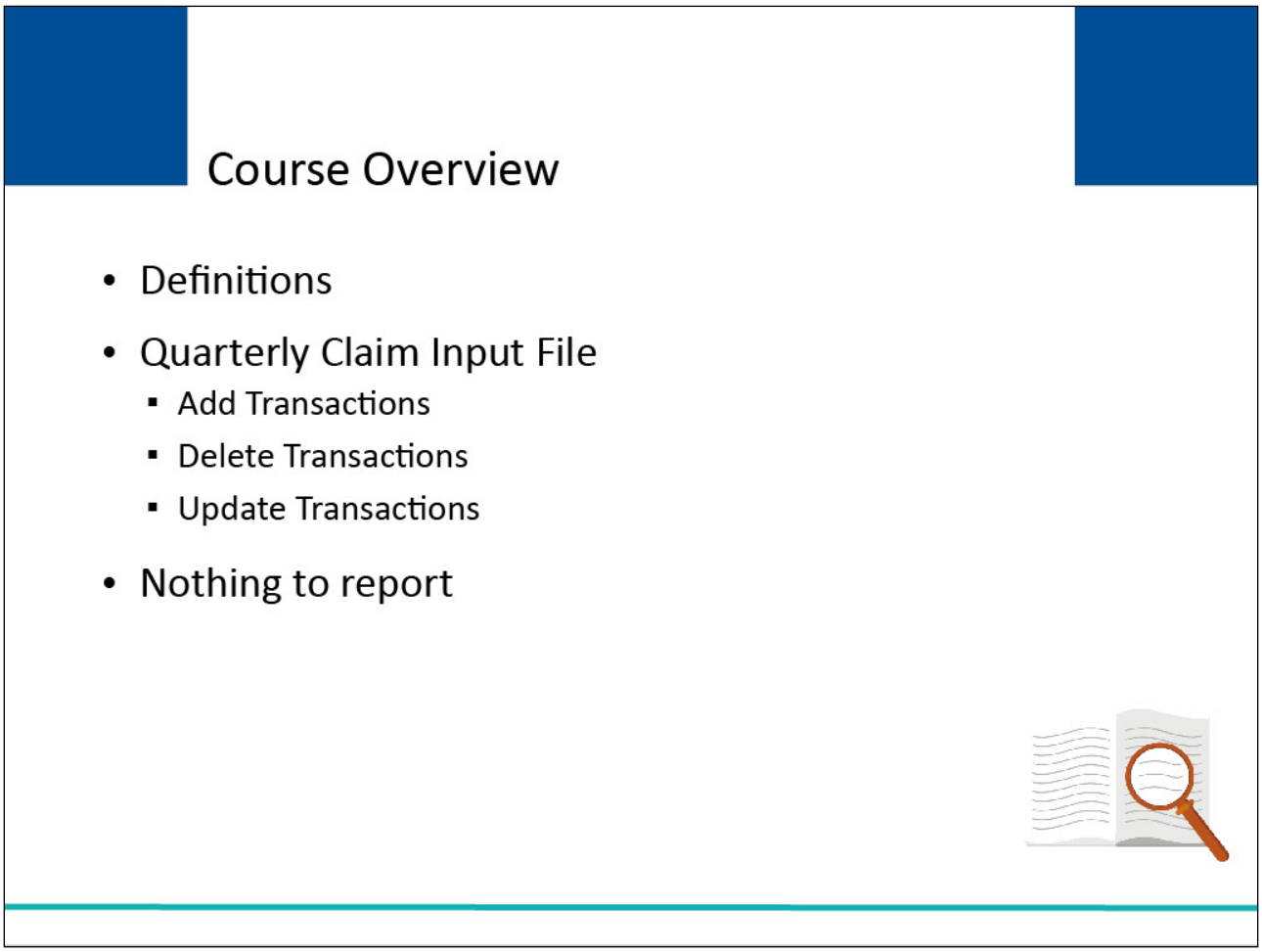


Slide notes

While all information in this document is believed to be correct at the time of writing, this Computer Based Training (CBT) is for educational purposes only and does not constitute official Centers for Medicare & Medicaid Services (CMS) instructions for the MMSEA Section 111 implementation.

All affected entities are responsible for following the instructions found at the following link: CMS NGHP Website.

Slide 3 of 38 - Course Overview



Slide notes

Upon completion of this course, you will be able to discuss the terminology used in this CBT and explain what is to be reported on the quarterly Claim Input File.

It describes the add, delete, and update transactions and when you would use each, and explains what to do when you don't have any Claim Detail Records or changes to report.

NOTE: Liability insurance (including self-insurance), no-fault insurance, and workers' compensation are sometimes collectively referred to as "non-group health plan" or "NGHP."

The term NGHP will be used in this CBT for ease of reference.

Important: Although information in this CBT pertains to the creation of the electronic Claim Input File, DDE submitters must adhere to essentially the same Section 111 reporting requirements and are also required to submit the same data on the Section 111 Coordination of Benefits Secure Website (COBSW).

Slide 4 of 38 - PAID Act

PAID Act

The Medicare Secondary Payer (MSP) policy is designed to ensure that the Medicare Program does not pay for healthcare expenses for which another entity is legally responsible. To aid settling parties in determining this information, Congress has enacted the Provide Accurate Information Directly Act also known as the PAID Act requiring that CMS provide Non-Group Health Plans with a Medicare beneficiary's Part C and Part D enrollment information for the past 3 years.

This information will be provided on the COBSW S111/MRA and offline in the NGHP Query Response File. Additionally, CMS has requested that this solution also include the most recent Part A and Part B Entitlement dates.

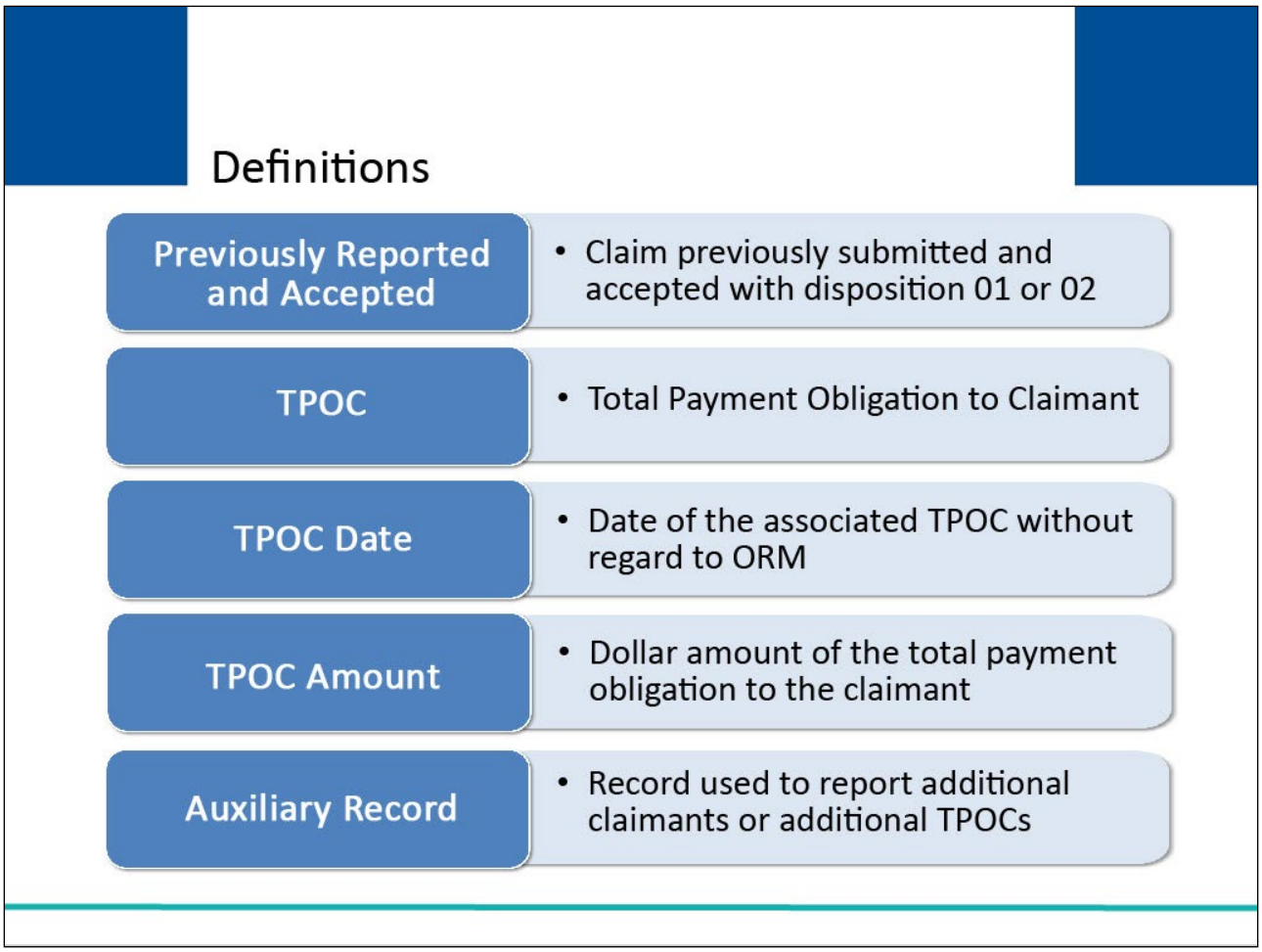
Slide notes

The Medicare Secondary Payer (MSP) policy is designed to ensure that the Medicare Program does not pay for healthcare expenses for which another entity is legally responsible. To aid settling parties in determining this information, Congress has enacted the Provide Accurate Information Directly Act also known as the PAID Act requiring that CMS provide Non-Group Health Plans with a Medicare beneficiary's Part C and Part D enrollment information for the past three years.

This information will be provided on the COBSW S111/MRA and offline in the NGHP Query Response File. Additionally, CMS has requested that this solution also include the most recent Part A and Part B Entitlement dates.

Note: To support the PAID Act, the Query Response File will be updated to include Contract Number, Contract Name, Plan Number, Coordination of Benefits (COB) Address, and Entitlement Dates for the last three years (up to 12 instances) of Part C and Part D coverage. The updates will also include the most recent Part A and Part B entitlement dates.

Slide 5 of 38 - Definitions



Slide notes

The phrase “previously reported and accepted” means that the RRE previously submitted a claim that was accepted by the Benefits Coordination & Recovery Center (BCRC) with a disposition code of 01 or 02 on the corresponding Claim Response File Detail Record.

TPOC is the Total Payment Obligation to Claimant.

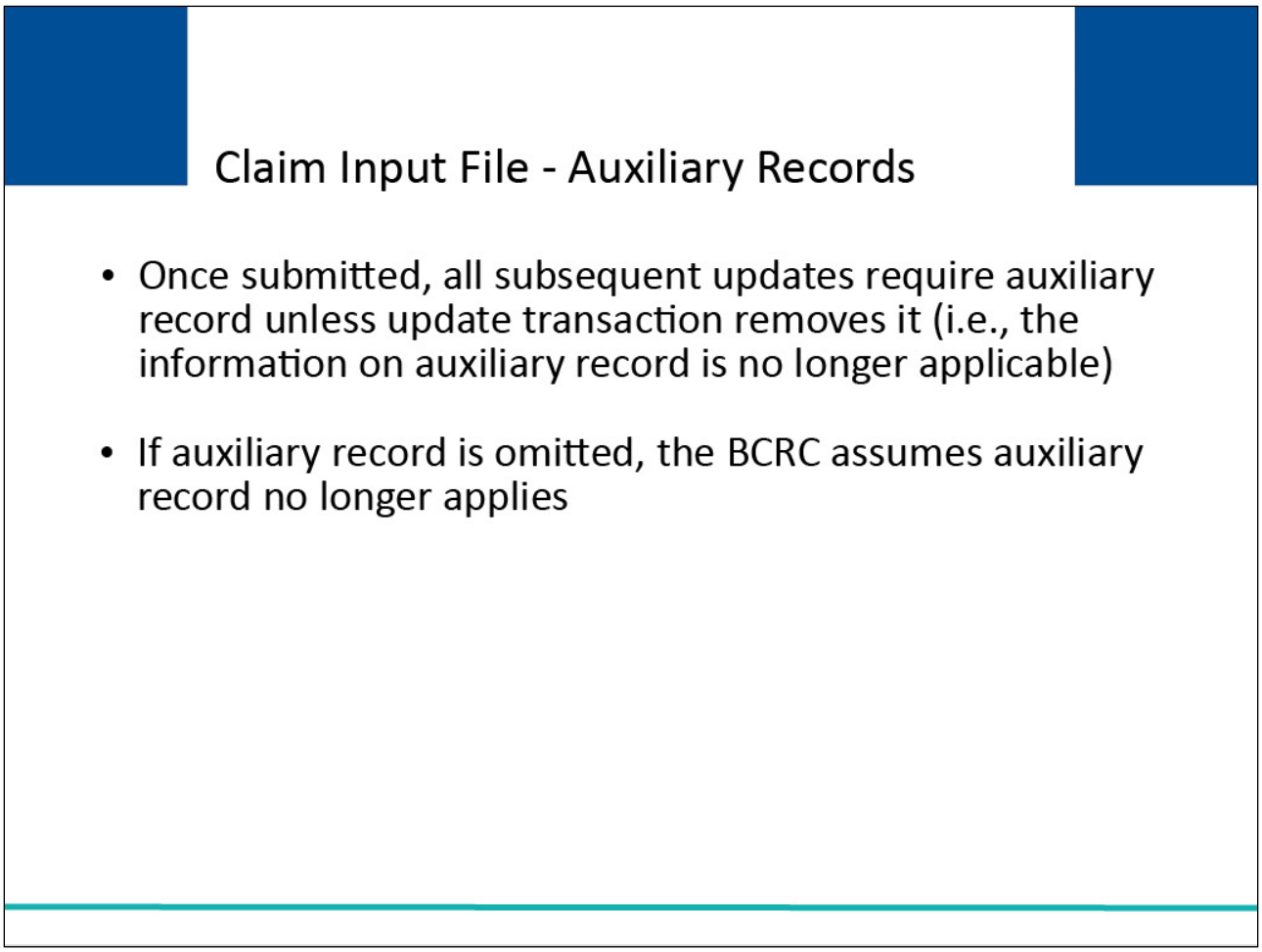
TPOC Date is the date of the associated TPOC without regard to ongoing responsibility for medicals (ORM).

TPOC Amount is the dollar amount of the total payment obligation to the claimant, i.e., dollar amount of a settlement, judgment, award, or other payment in addition to/apart from ORM. Additional information has been added regarding the computation of Total Payment Obligation to Claimant (TPOC) amounts, and the language around the reporting of indemnity-only settlements or payments by RREs has been clarified. This can be found in the NGHP User Guide.

The Auxiliary Record is a separate record that is associated to a detail record. The RRE is required to use this record to report information regarding additional claimants and/or information related to additional TPOC Dates/Amounts.

Please refer to the Total Payment Obligation to Claimant CBT for clarification on TPOC Date, TPOC Amount, and use of the Auxiliary Record.

Slide 6 of 38 - Claim Input File - Auxiliary Records

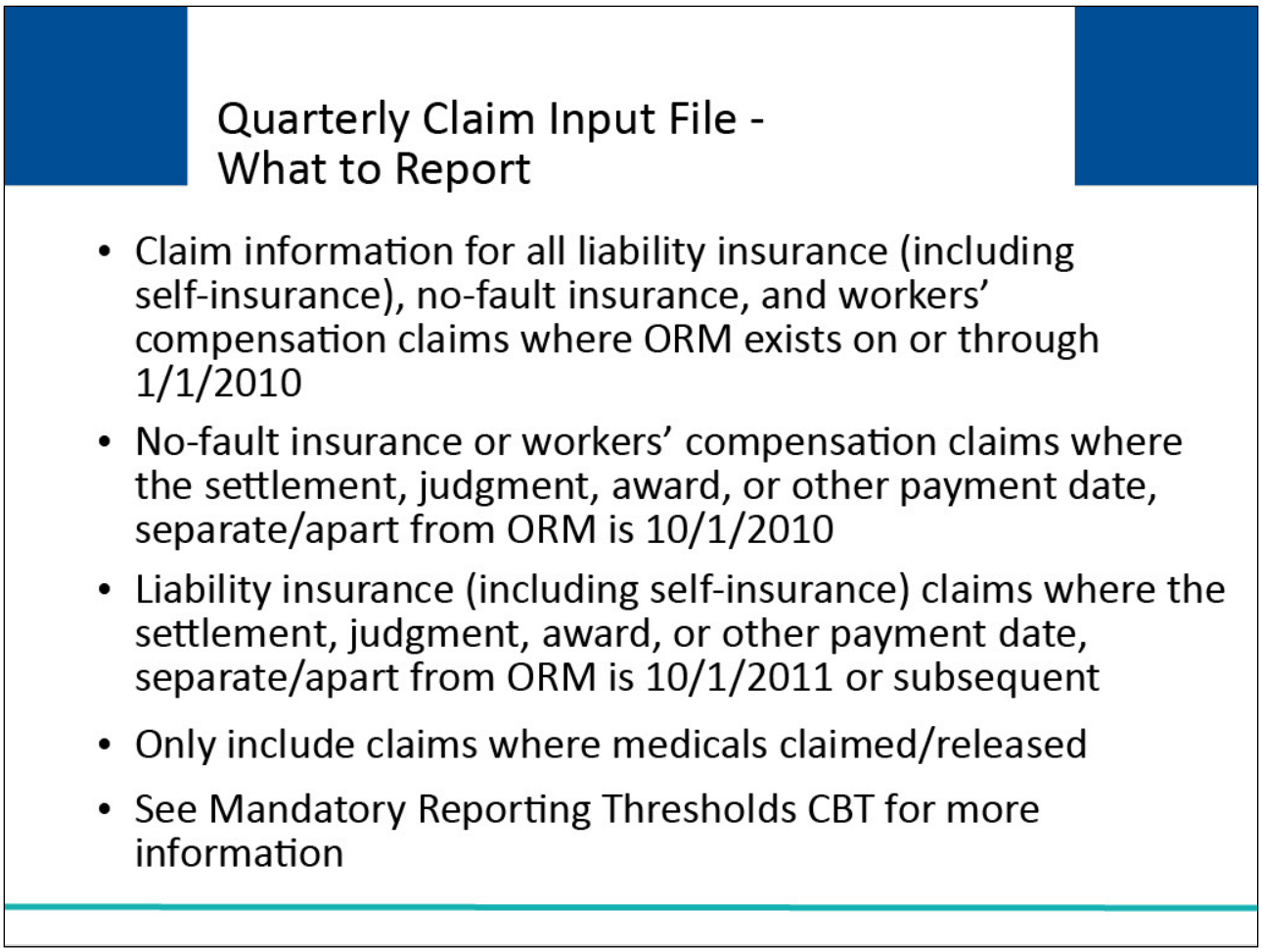


Slide notes

Once an RRE submits an auxiliary record with a Claim Input File Detail Record, all subsequent update transactions for that Claim Detail Record must include the auxiliary record, unless the update transaction removes that information from the report (i.e., the information on the auxiliary record is no longer applicable to the claim, and the RRE is removing all of it).

If a previously reported auxiliary record is not included on a subsequent Claim Input File, the BCRC will assume that the previous information reported on the auxiliary record no longer applies to the Claim Detail Record.

Slide 7 of 38 - Quarterly Claim Input File - What to Report



Slide notes

RREs are required to create and send a Claim Input File on a quarterly basis for each RRE ID established.

These file submissions must include information for all liability insurance (including self-insurance), no-fault insurance, and workers' compensation claims involving a Medicare beneficiary as the injured party where ongoing responsibility for medical payments exists as of January 1, 2010, and subsequent, regardless of the date of an initial acceptance of payment responsibility.

In addition, they must include no-fault insurance or workers' compensation claims where the settlement, judgment, award, or other payment date, separate/apart from ORM, is October 1, 2010, or subsequent, and which meet the reporting thresholds for Section 111.

Liability insurance (including self-insurance) claims must be reported where the settlement, judgment, award, or other payment date, separate/apart from ORM, is October 1, 2011, or subsequent.

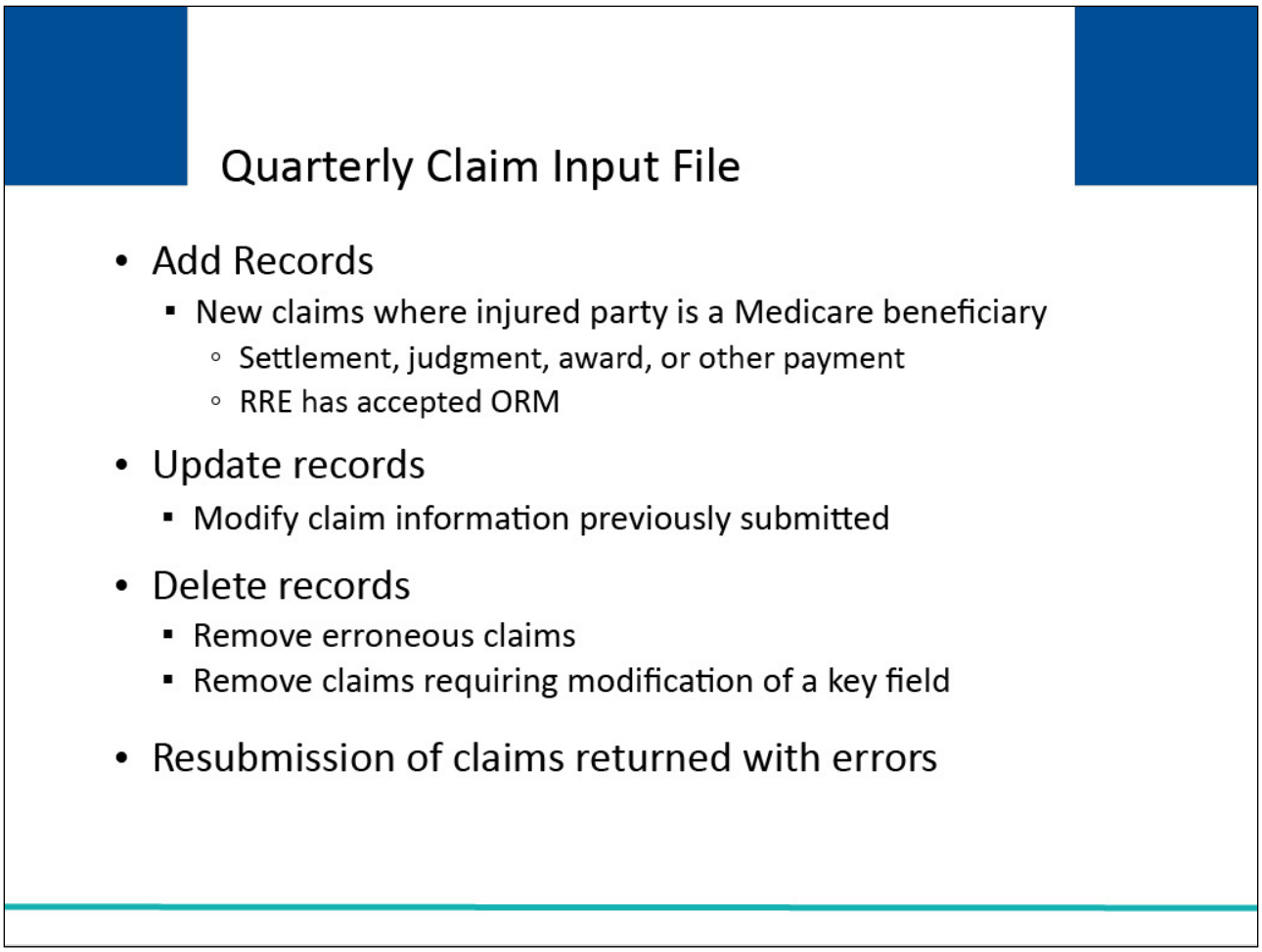
RREs should only include claims for which medicals have been claimed and/or released, or the settlement, judgment, award, or other payment has the effect of releasing medicals.

Note: In some states, depending on various factors associated with the incident being reported, no-fault policy limits may vary. The reported Policy Limit should reflect the amount that the RRE has accepted responsibility for at the time the record was submitted or updated. Just as importantly, if the Section 111 record needs to be corrected to reflect a new Policy Limit, the RRE should update the record as soon as possible.

Also, as of January 1, 2022, the threshold for physical trauma-based liability insurance settlements will remain at $750. CMS will maintain the $750 threshold for no-fault insurance and workers' compensation settlements, where the no-fault insurer or workers' compensation entity does not otherwise have ongoing responsibility for medical (ORM).

Please see the Mandatory Reporting Thresholds CBT for more information. RREs are responsible for ensuring that they adhere to these requirements.

Slide 8 of 38 - Quarterly Claim Input File



Slide notes

Quarterly Claim Input File submissions will include records for new claims as add records where the injured party is/was a Medicare beneficiary, reflecting settlement, judgment, award, or other payment, and assumption of ORM since the last file submission.

Your file may also contain updated and/or delete records. Update records are used to modify claim information on detailed records previously submitted and accepted by the BCRC.

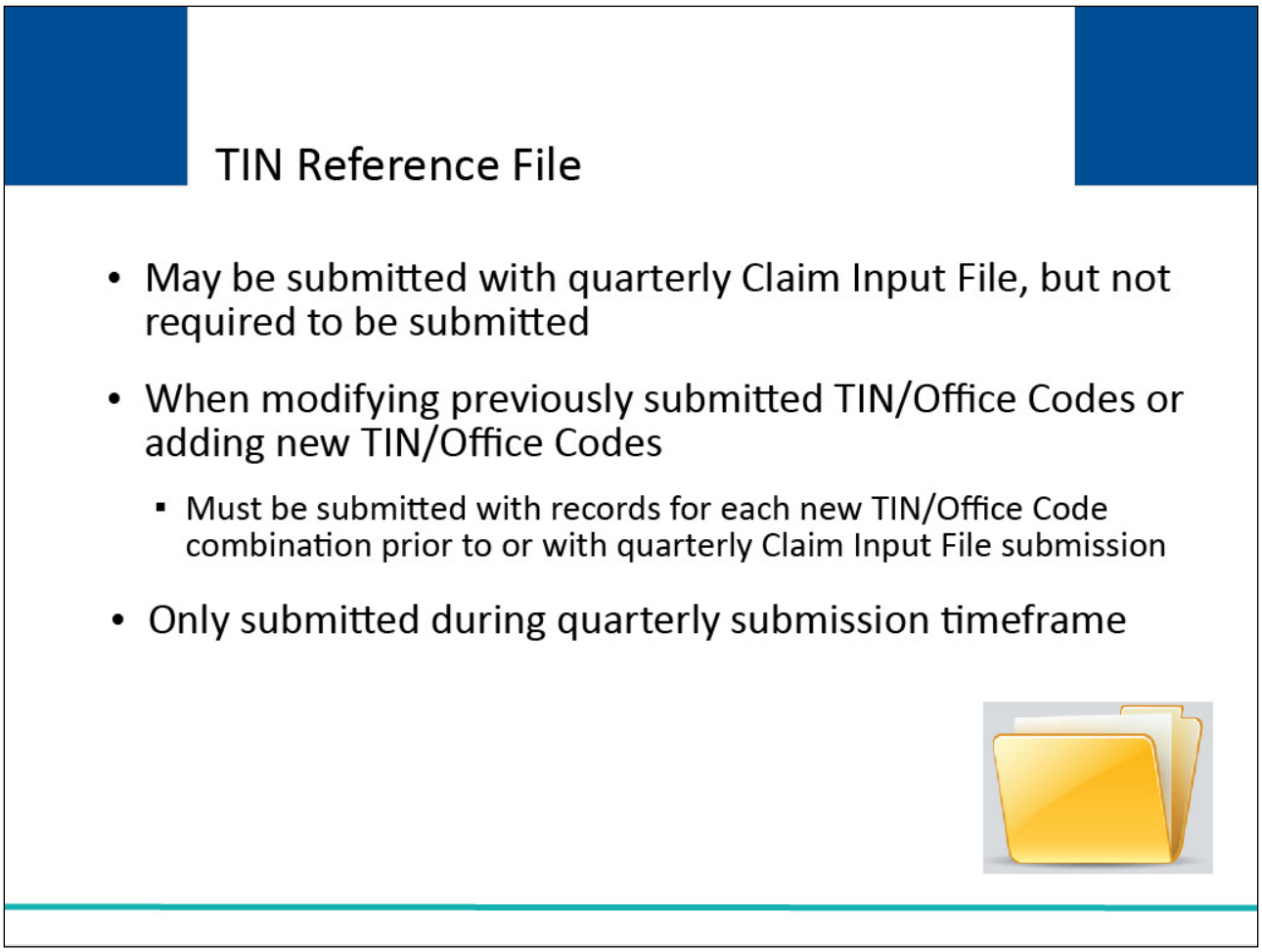
Delete records are used to remove Claim Detail Records that were previously submitted in error or to remove Claim Detail Record(s) when modification of a key field(s) is required.

Your file must also include the resubmission of all records found to be in error on the previous file, with corrections made.

When the RRE resubmits these corrected Claim Detail Records, they will use the same Action Type previously reported for the Claim Detail Record (0 for Adds, 1 for Deletes, or 2 for Updates).

Note: A record is considered accepted by the BCRC if the corresponding response record is returned with a disposition code of 01 or 02.

Slide 9 of 38 - TIN Reference File



Slide notes

You may submit the Tax Identification Number (TIN) Reference File when you submit the quarterly Claim Input File but are not required to.

However, if you are modifying previously submitted TIN/Office Code information or if you are adding new TIN/Office Code combinations, you must submit a TIN Reference File with records for each new TIN/Office Code combination prior to or with your quarterly Claim Input File submission.

TINs will be verified, so it is imperative that accurate information be provided in the file. You can only submit an updated TIN Reference File during your quarterly submission timeframe.

Note: When there is an active Medicare Secondary Payer Recovery Portal (MSPRP) account for the insurer/recovery agent TIN, Section 111 submitters may set Go Paperless options (i.e., choose to receive letters electronically or by mail) for the insurer and recovery agent address using the following new TIN Reference File fields:

- TIN/Office Code Paperless Indicator (Field 23)
- Recovery Agent Paperless Indicator (Field 24)
- Recovery Agent TIN (Field 25)

- There are also five new fields (Fields 48-52) returned for these entries on the TIN Reference Response File.

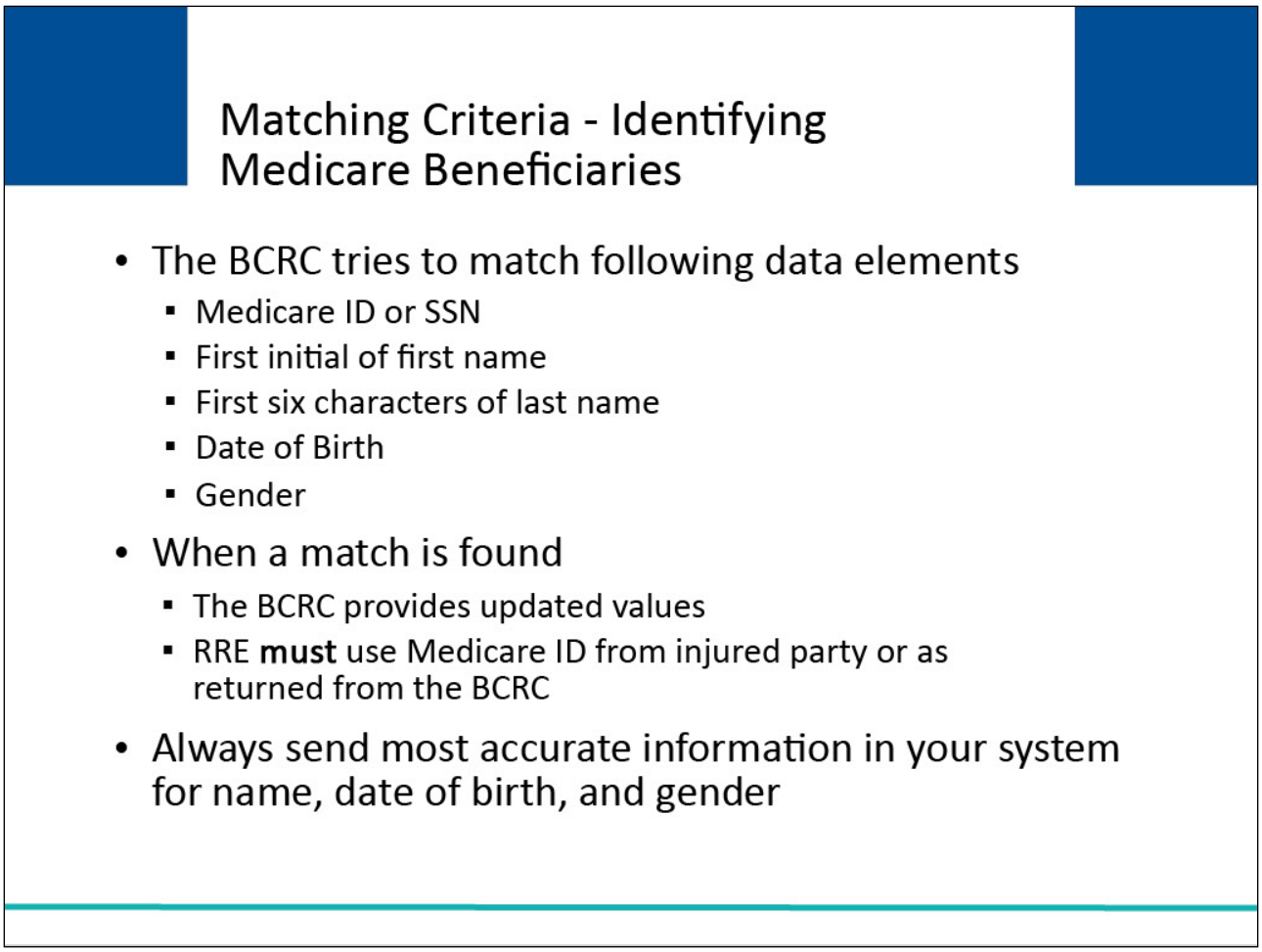
Also note: Recovery agents may now view the Open Debt Report on the MSPRP, if the agent has an active MSPRP account with a TIN matching one submitted on the RRE's TIN Reference File.

Additionally, as of July 2023, RREs will be notified when another source has updated their submitted records. RREs may now opt-in via the Section 111 Coordination of Benefits Secure Website (COBSW) application to receive a monthly NGHP Unsolicited Response File. This will provide key information about updates to ORM records originally submitted in the last 12 months and allow RREs to either update their own internal data or contact the BCRC for a correction. Also note the modifier type codes CEM (Employer/Other Plan Sponsor Name), DSA (Name of the Voluntary Data Sharing Agreement (VDSA) entity), and PRV (From a Provider) will not be used in the NGHP Unsolicited Response File and have been removed from the list.

Please be aware as of July 12, 2023 Notice Regarding the Receipt of Empty (Header & Trailer Record Only) Non-Group Health Plan (NGHP) Unsolicited Response Files

Questions have been received from NGHP Responsible Reporting Entities (RREs) regarding receipt of empty (header and trailer record only) Unsolicited Response Files. Please be aware that a file will be transmitted regardless of record count. This means that an RRE that has opted in to receive the Unsolicited Response File will always receive a file that includes any updates made in the last 30 days. If there are no records updated by an outside source that are linked to that RRE ID in that timeframe, the Unsolicited Response File will be empty. Please note that the Non-Group Health Plan User Guide will also be updated to clarify the receipt of empty files.

Slide 10 of 38 - Matching Criteria - Identifying Medicare Beneficiaries



Slide notes

When you submit a Claim Input File Detail Record, the BCRC must determine if the injured party you submitted can be identified as a Medicare beneficiary. They will attempt to match the following submitted data elements to Medicare's data:

- Medicare ID or Social Security Number (SSN)
- First initial of the first name
- First six characters of the last name
- Date of birth (DOB)
- Gender

In order for a record to be accepted by the BCRC, an exact match must be found on the Medicare ID or SSN (i.e. the last 5 digits or full 9 digits of the SSN, whichever is submitted) and then an exact match must be found on at least three out of the four other fields (four out of four when a partial SSN is used).

When a match is found, the BCRC will provide updated (applied) values for these fields, on the response file.

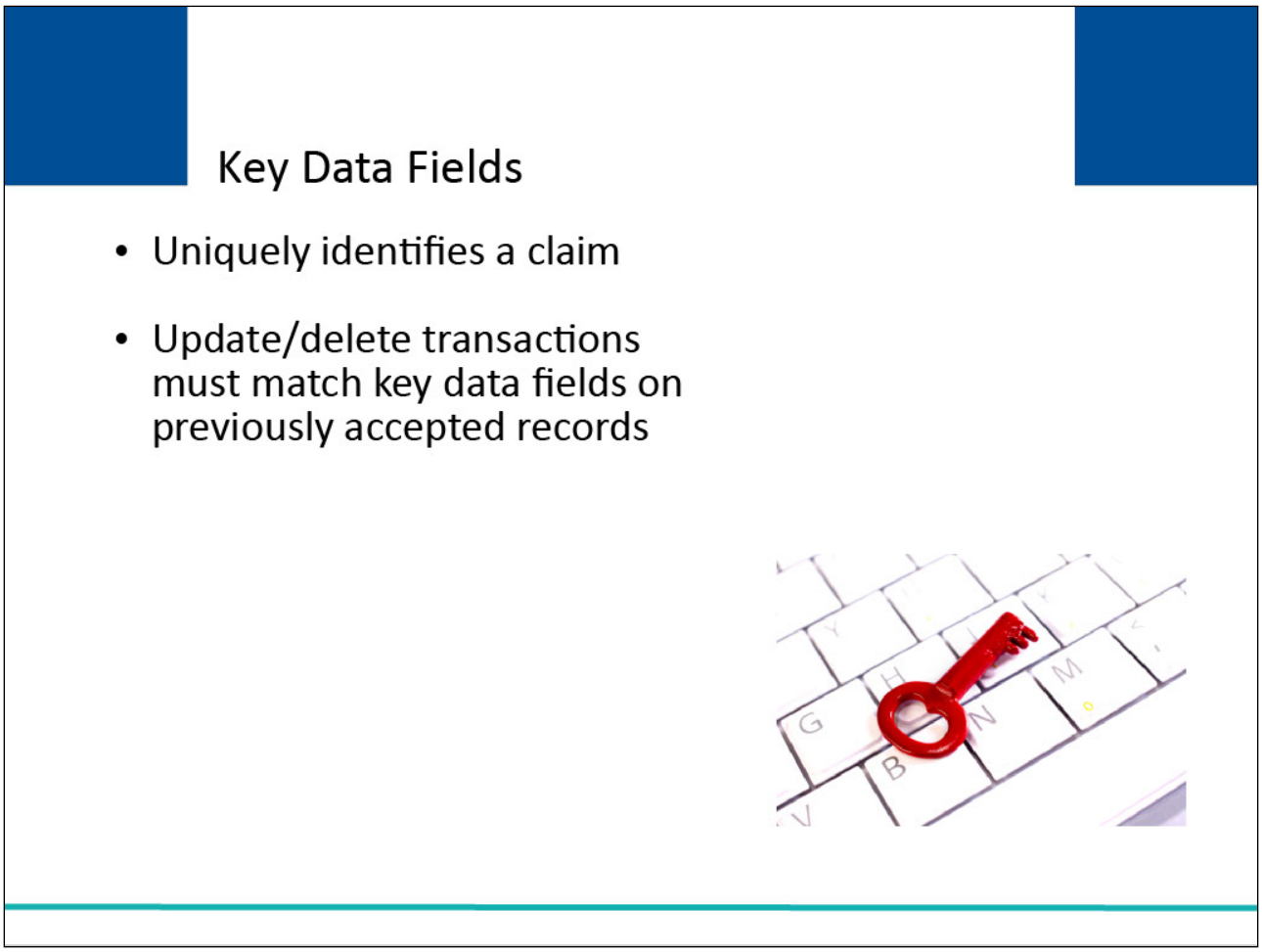
It is important to note that RREs must always use the Medicare ID assigned to the injured party whenever made available by the injured party or as returned by the BCRC, as this is the official individual identifier used by Medicare for Medicare beneficiaries.

Enter slide note

If an RRE submits both the SSN and Medicare ID on a claim or query record, the system will only use the Medicare ID for matching purposes, and the SSN will be ignored.

Additionally, when you send add, update, or delete transactions, you should always send the most recent, most accurate information you have in your system for name, date of birth, and gender on all transactions, as it will aid in the matching process.

Slide 11 of 38 - Key Data Fields



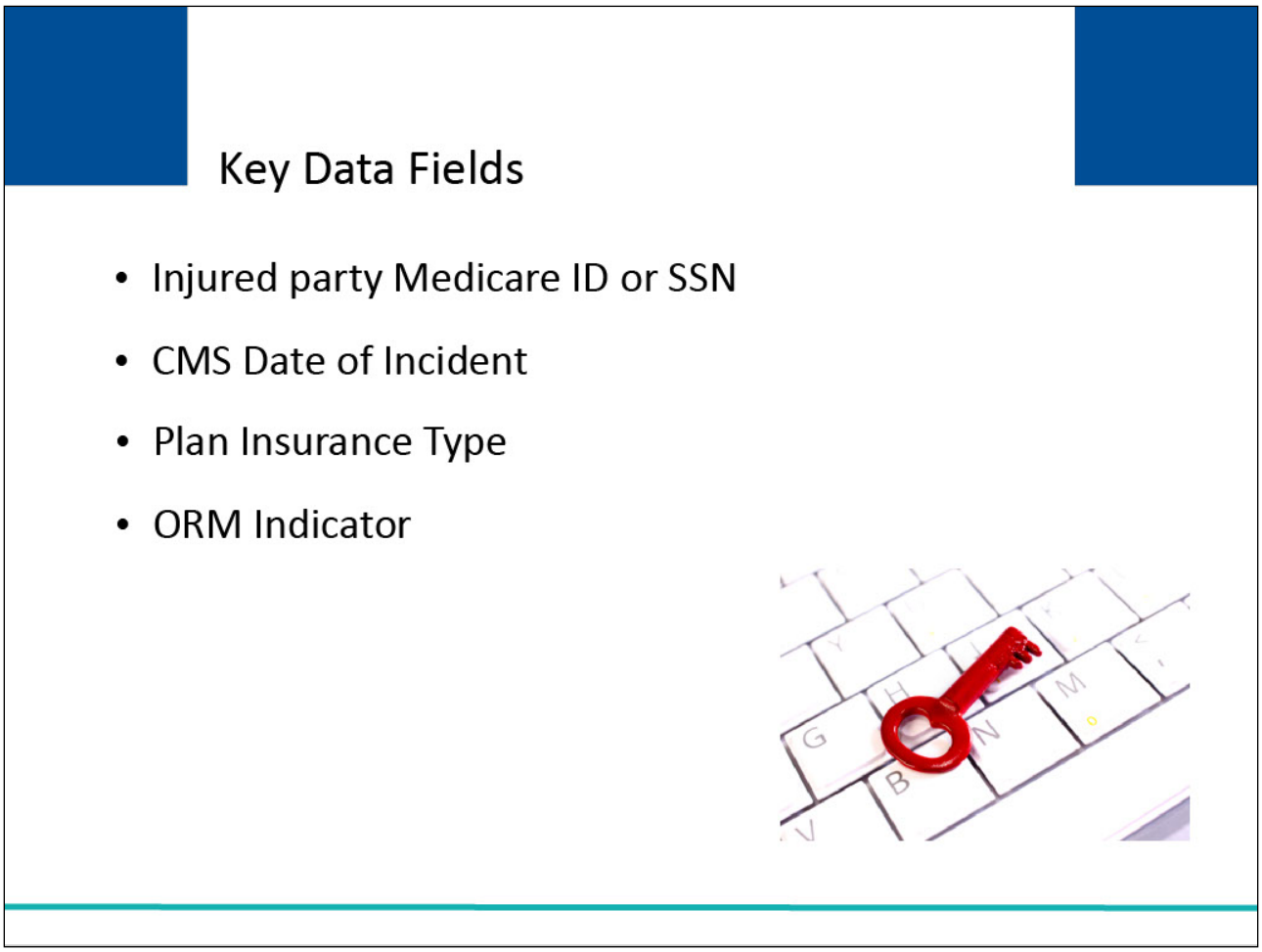
Slide notes

Once a Claim Detail Record is processed and accepted, the BCRC uses key data fields to uniquely identify the claim for future processing.

In order for an update/delete transaction to be successful, the key data fields on an update/delete record must match the key data fields on the previously accepted detail record.

Note: The verbiage on the S111 COBSW No Transactions Remaining page (i.e., the page that displays when the DDE submitter has depleted their yearly allotment of claim submissions), has been revised to alert you to contact your EDI Representative if you need additional transactions.

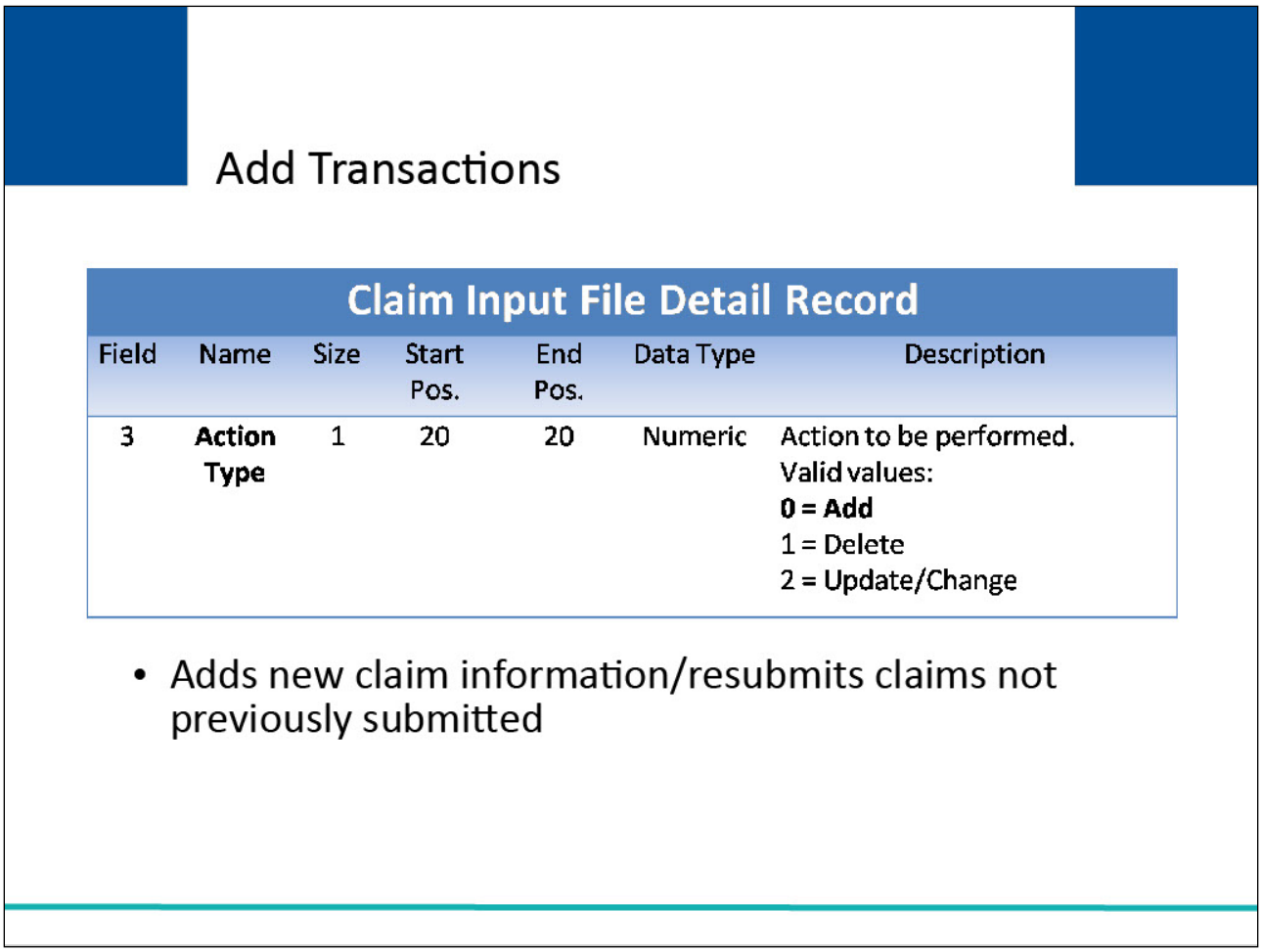
Slide 12 of 38 - Key Data Fields



Slide notes

Note: The verbiage on the S111 COBSW No Transactions Remaining page (i.e., the page that displays when the DDE submitter has depleted their yearly allotment of claim submissions), has been revised to alert you to contact your EDI Representative if you need additional transactions.

Slide 13 of 38 - Add Transactions



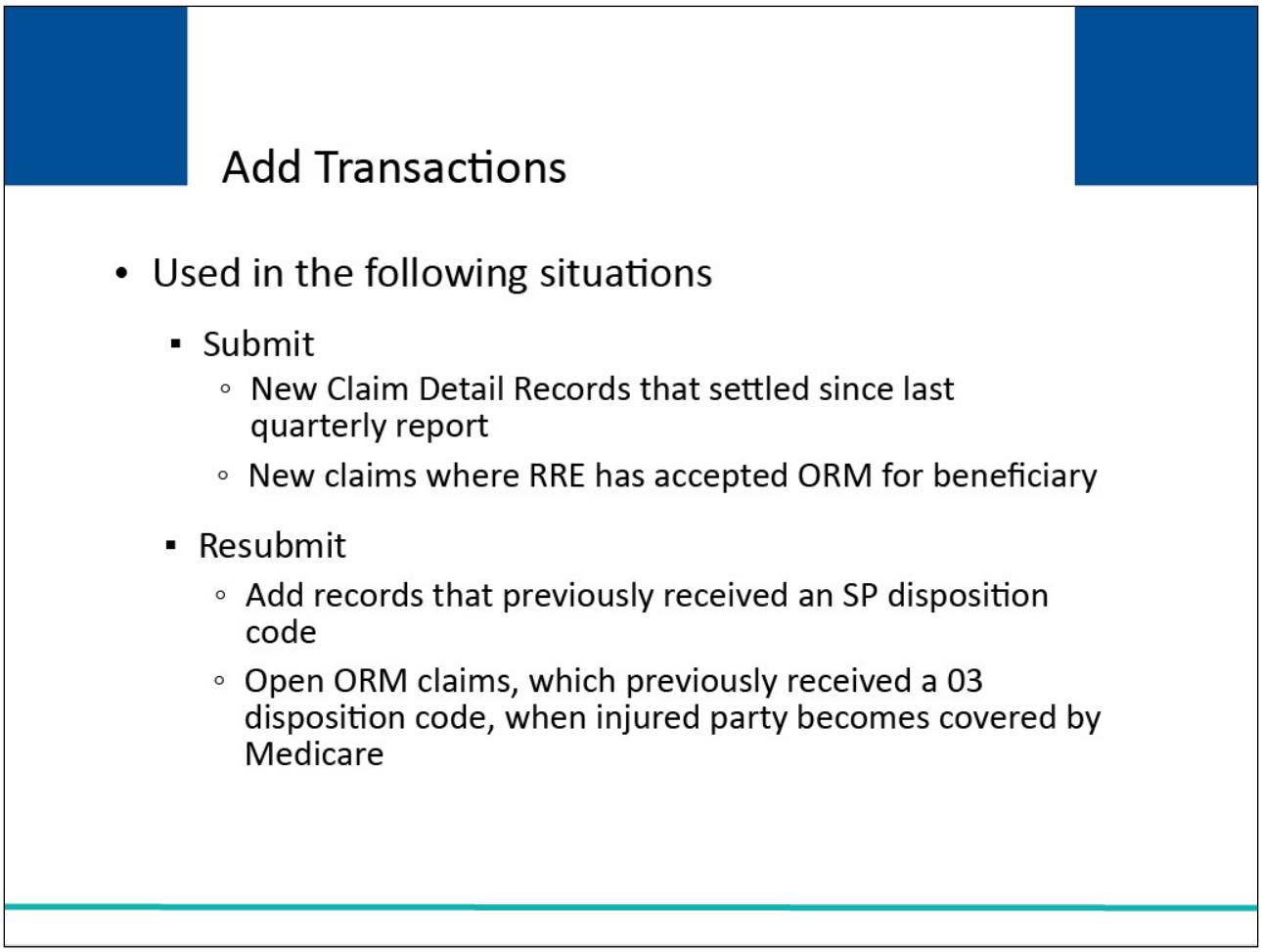
Slide notes

Three different types of detail records will be submitted on the Claim Input File, and they are distinguished using the Action Type Field.

An add record or transaction is defined with a 0 (zero) in the Action Type (Field 3) of a Claim Input File Detail Record.

An add transaction is used to add new claim information that was either not previously submitted or was submitted but not accepted.

Slide 14 of 38 - Add Transactions



Slide notes

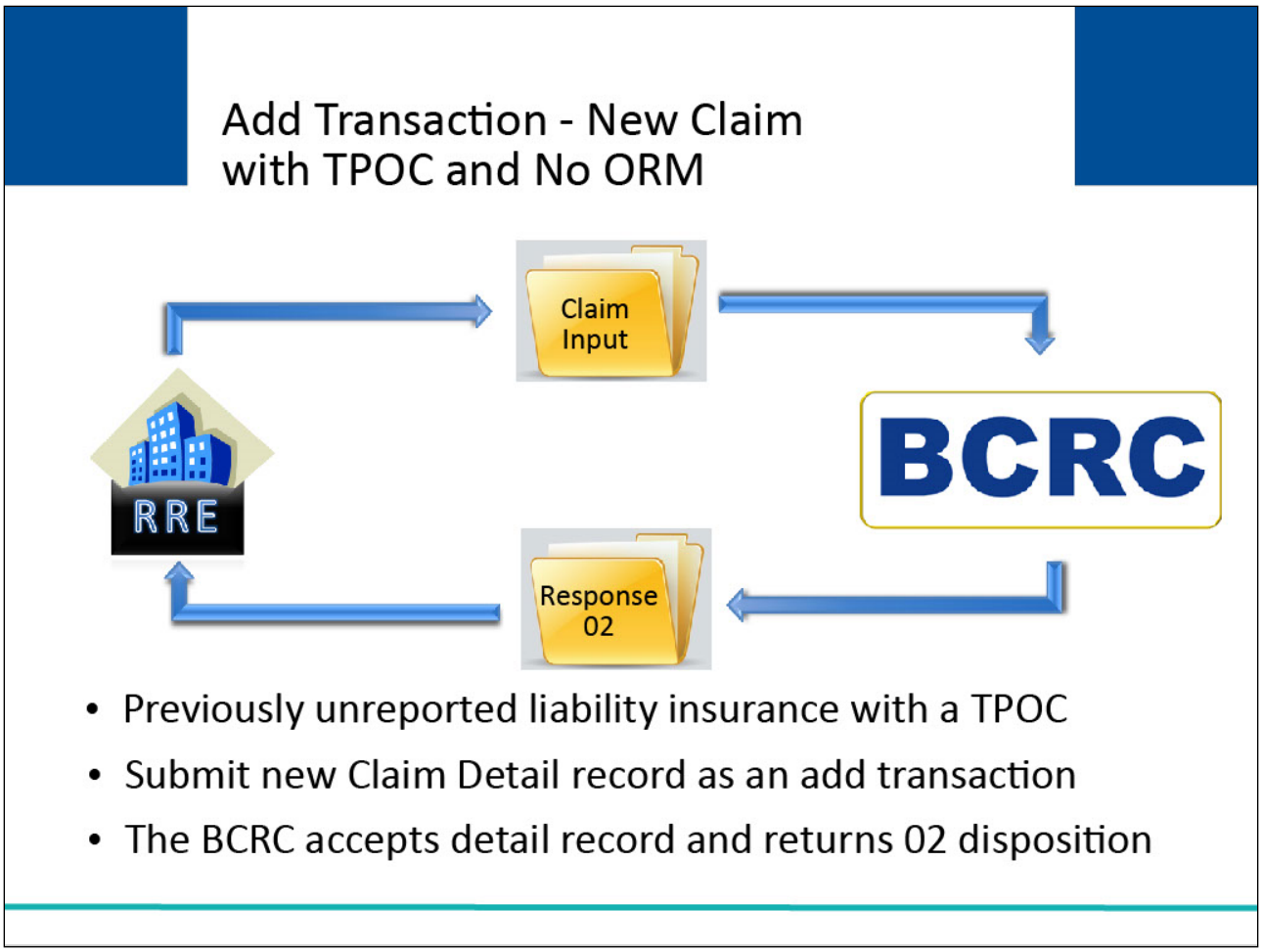
Add records will be used for the following situations:

- To submit new Claim Detail Records that settled since your last quarterly report
- To submit new Claim Detail Records where the RRE has accepted ORM for a Medicare beneficiary
- To resubmit add records that previously had errors (i.e., received an SP disposition code) on the response file, or
- To resubmit open ORM claims, which previously received a 03 disposition code, when the injured party becomes covered by Medicare

Following are examples to enhance your understanding of how to submit Claim Input File Detail add records.

Please note, there is a CBT titled Claim Input File Events, which includes additional add, update, and delete examples to aid you in your understanding of how/when to submit Claim Input File Detail Records.

Slide 15 of 38 - Add Transaction - New Claim with TPOC and No ORM



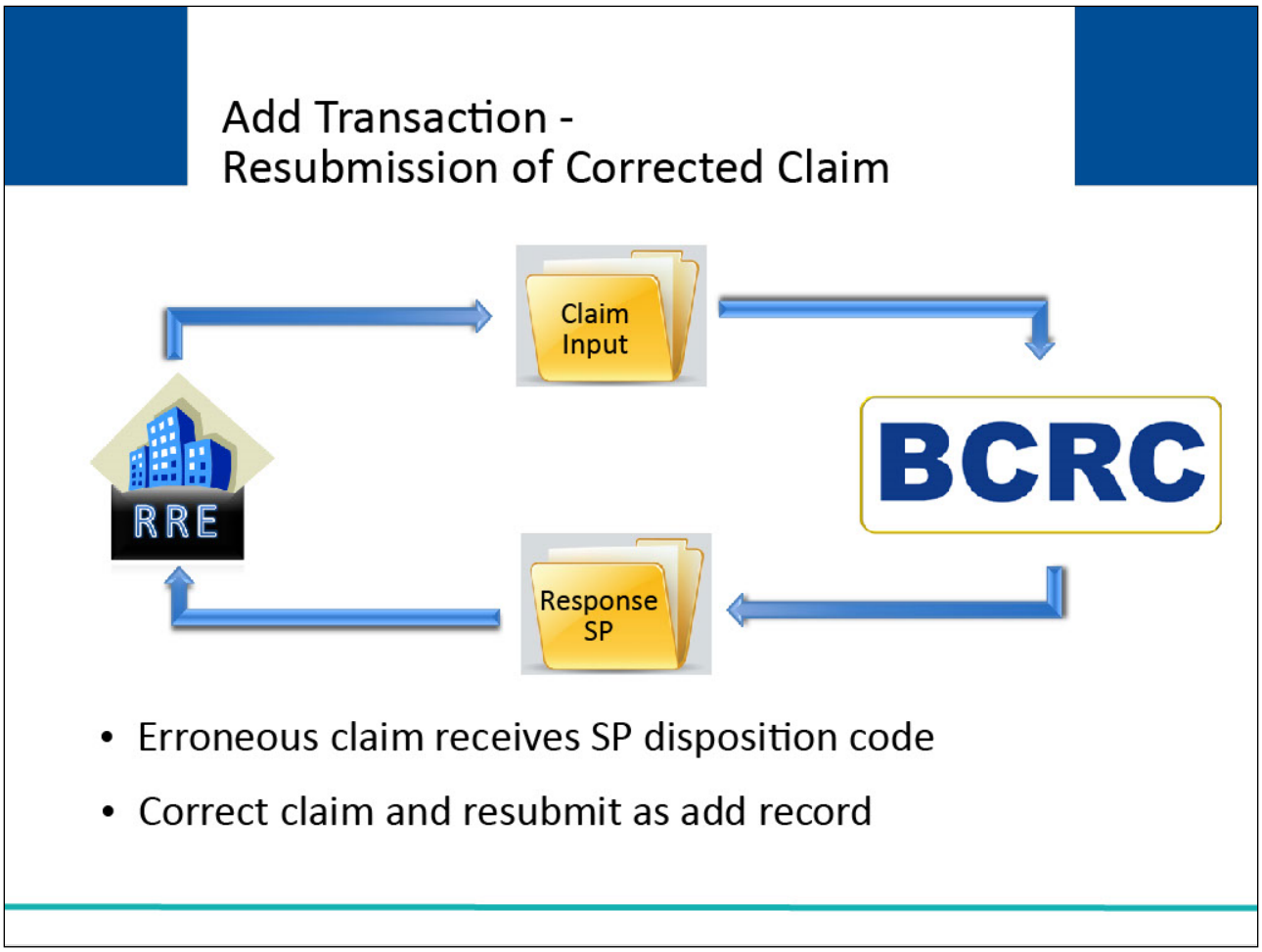
Slide notes

An RRE has begun submitting production Section 111 Claim Input Files and received and processed last quarter's responses from the BCRC.

A new liability insurance claim not previously submitted has a settlement, judgment, award, or other payment TPOC. The RRE submits information for the new claim as an add record on the next quarterly file submission.

The RRE has indicated no ORM. The BCRC accepts and adds the record to the Medicare files and returns a 02 disposition code.

Slide 16 of 38 - Add Transaction - Resubmission of Corrected Claim



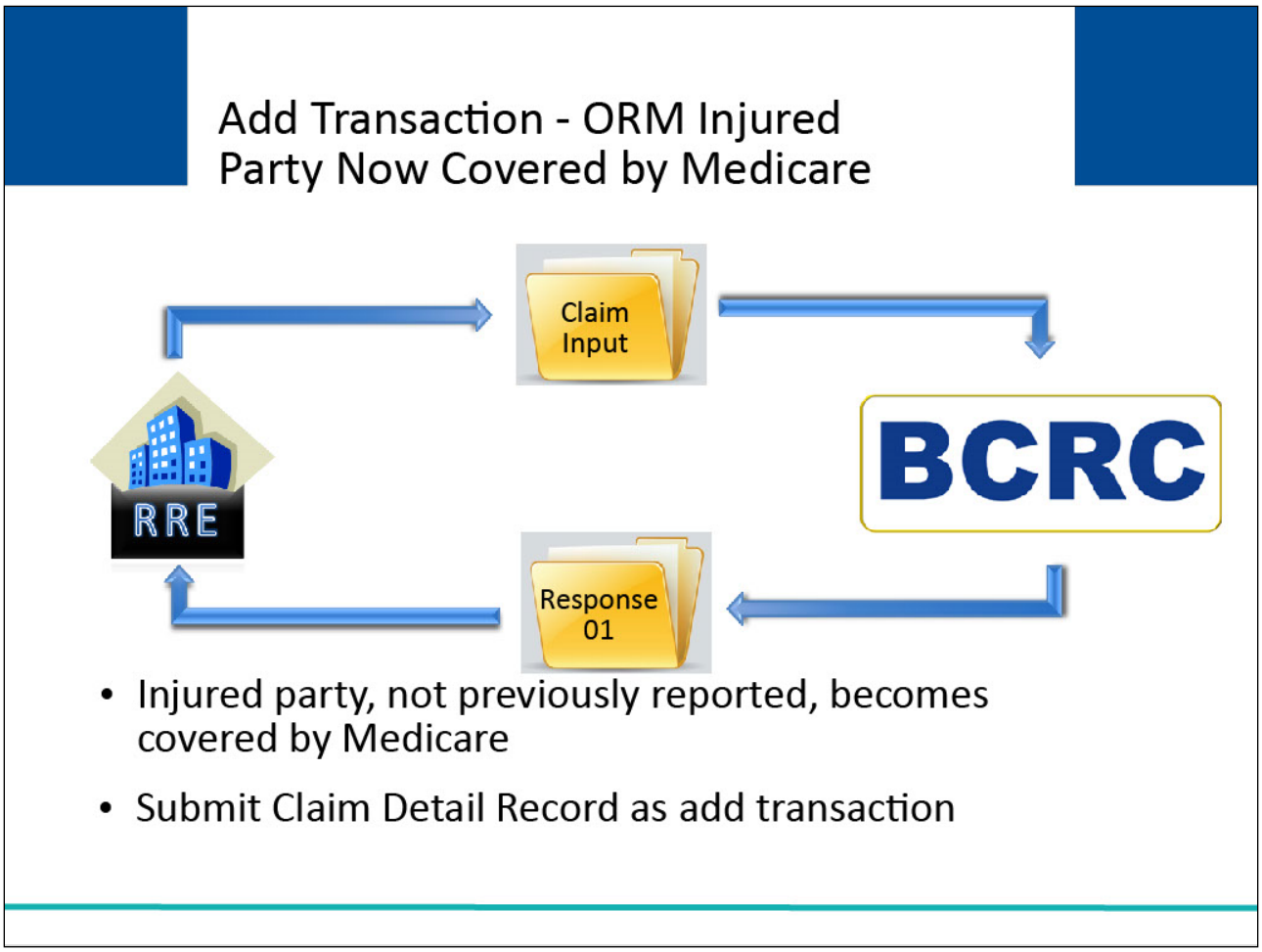
Slide notes

An RRE has begun submitting production Section 111 Claim Input Files and received and processed last quarter's responses from the BCRC.

A Claim Detail Record submitted on last quarter's file as an add record was in error and received an SP disposition code with errors listed on the response record.

The RRE corrects the claim and resubmits it as an add record on the next quarterly file submission.

Slide 17 of 38 - Add Transaction - ORM Injured Party Now Covered by Medicare



Slide notes

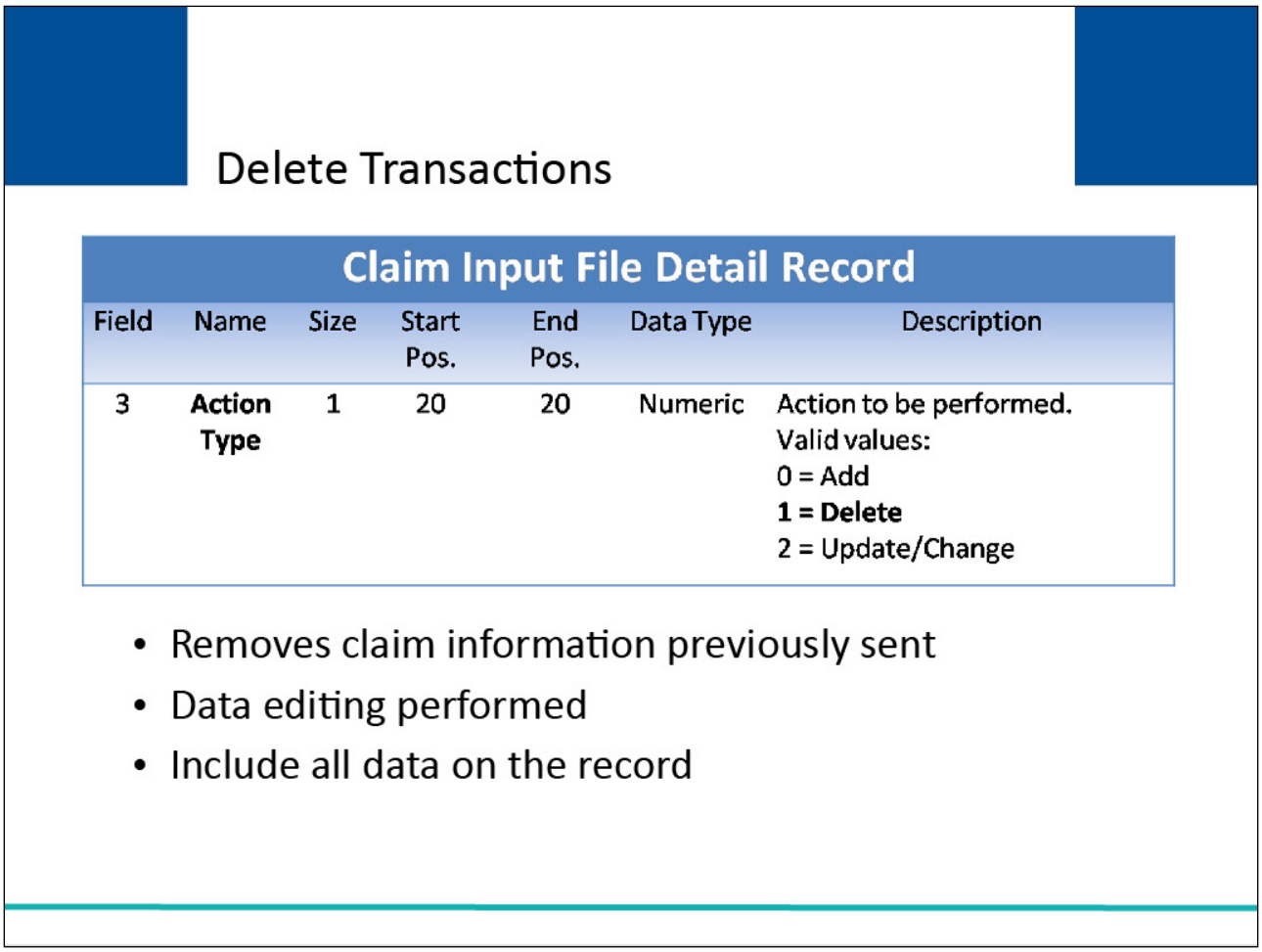
An RRE has begun submitting production Section 111 Claim Input Files and received and processed last quarter's responses from the BCRC.

The RRE determines that an injured party on a Claim Detail Record where the RRE has ORM under Section 111 becomes covered by Medicare.

The RRE determines this through its monitoring process (which may include, for example, notification from the injured party or information through the Section 111 query process).

The RRE submits the claim as an add record on the next quarterly file submission. The BCRC accepts and adds the record to the Medicare files and returns a 01 disposition code.

Slide 18 of 38- Delete Transactions



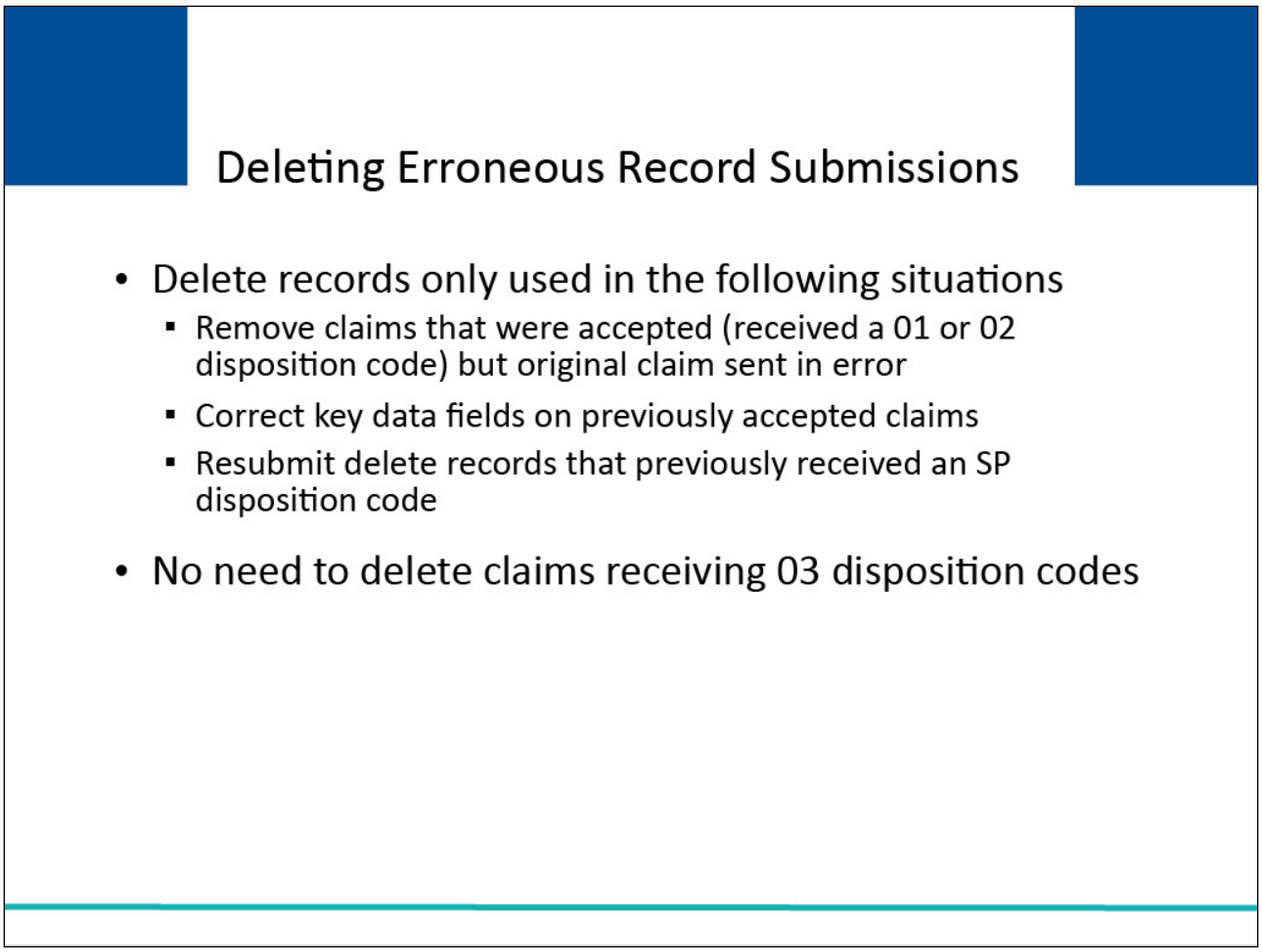
Slide notes

A delete record or transaction is defined with a 1 in the Action Type (Field 3) of a Claim Input File Detail Record. A Delete transaction is sent to remove claim information previously sent for Section 111 to the BCRC.

Data editing is performed on Delete transactions to ensure that the information provided is accurate, complete, and consistent. Ensure that all data is included on the record to ensure the record passes data edits.

Refer to the NGHP User Guide and Claim Input File Data Elements course for additional information on data editing.

Slide 19 of 38 - Deleting Erroneous Record Submissions



Slide notes

Delete records will only be used in the following situations.

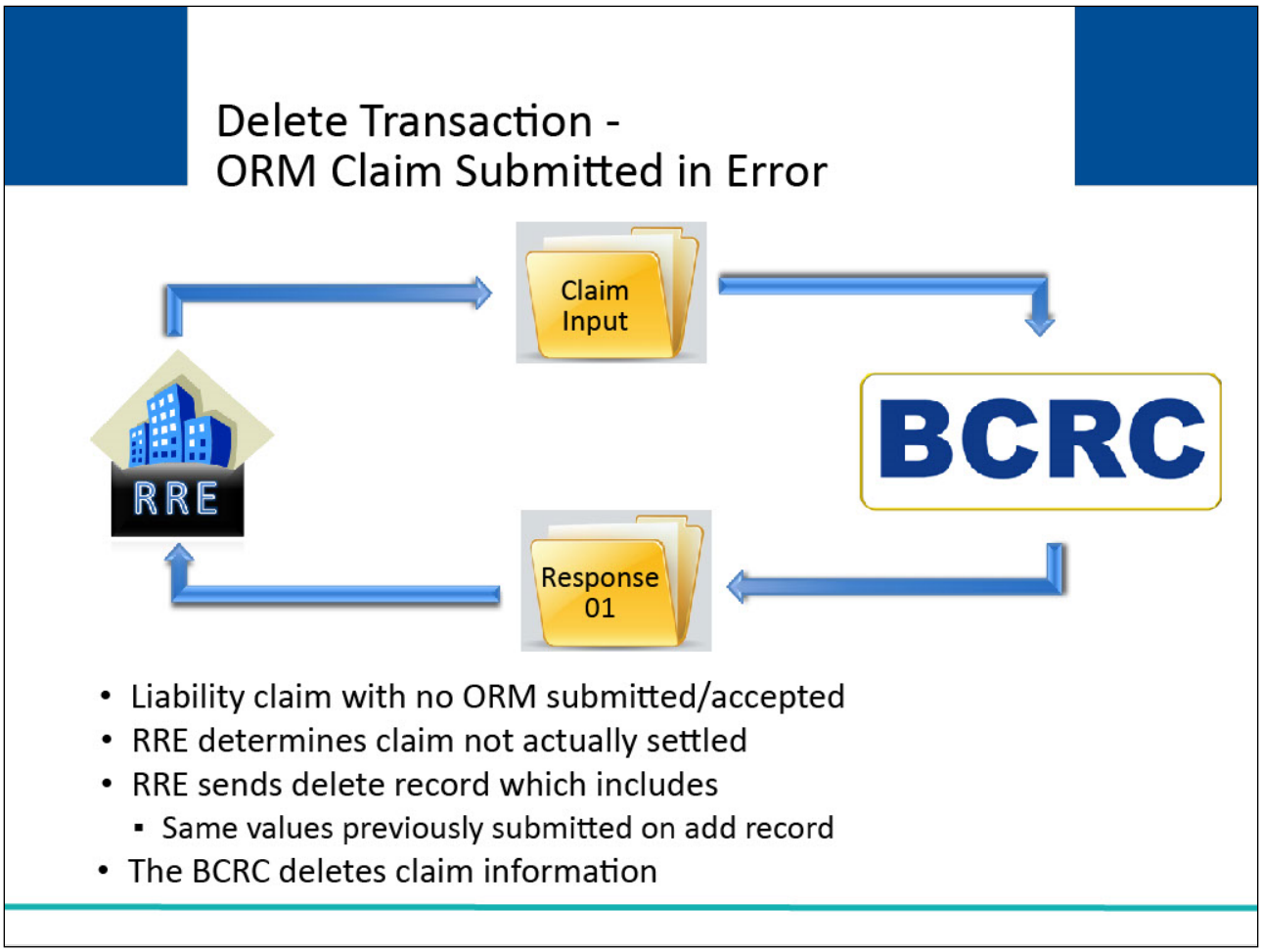
The first is to remove a detail record that was previously sent and accepted by the BCRC (i.e., the claim received a 01 or 02 disposition code in the Claim Response File), but the original detail record was sent in error (e.g., the Claim Detail Record was not actually settled).

The second situation that requires a delete transaction is when the RRE needs to correct data in one or more of the key fields that are used to identify claims on a previously accepted detail record.

You will also use a delete transaction to resubmit a delete record that previously received an SP disposition code on the response file. Delete records are not necessary for records that received a 03 disposition code.

Following are examples to enhance your understanding of how to submit Claim Input File Detail delete records.

Slide 20 of 38 - Delete Transaction - ORM Claim Submitted in Error



Slide notes

A Claim Detail Record was submitted for a settled liability claim with no ORM on an RRE's previous quarterly file submission and was accepted with a 02 disposition code (i.e., claim accepted, no ORM).

Subsequently, the RRE discovers an internal system error and realizes that this Claim Detail Record is not, in fact, settled, and no payment was made by the RRE.

On its next Claim Input File, the RRE sends a delete record that includes the same values previously submitted on the accepted add record and places a 01 in the Action Type.

The BCRC accepts the record, deletes the claim information from internal Medicare files, and returns a 01 disposition code for the deleted record.

Note: For liability claims, it is now optional to report 'NOINJ' codes in certain circumstances (NGHP User Guide, Section 6.2.5.2)

Slide 21 of 38 - Key Data Fields

Key Data Fields

- Medicare stores claims information using key data fields
- If an RRE needs to correct a key field submitted previously, the RRE must send
  - Delete record with the key information that matches the previously accepted add record
  - Add record with the changed information
- This is often referred to as the “delete/add” process

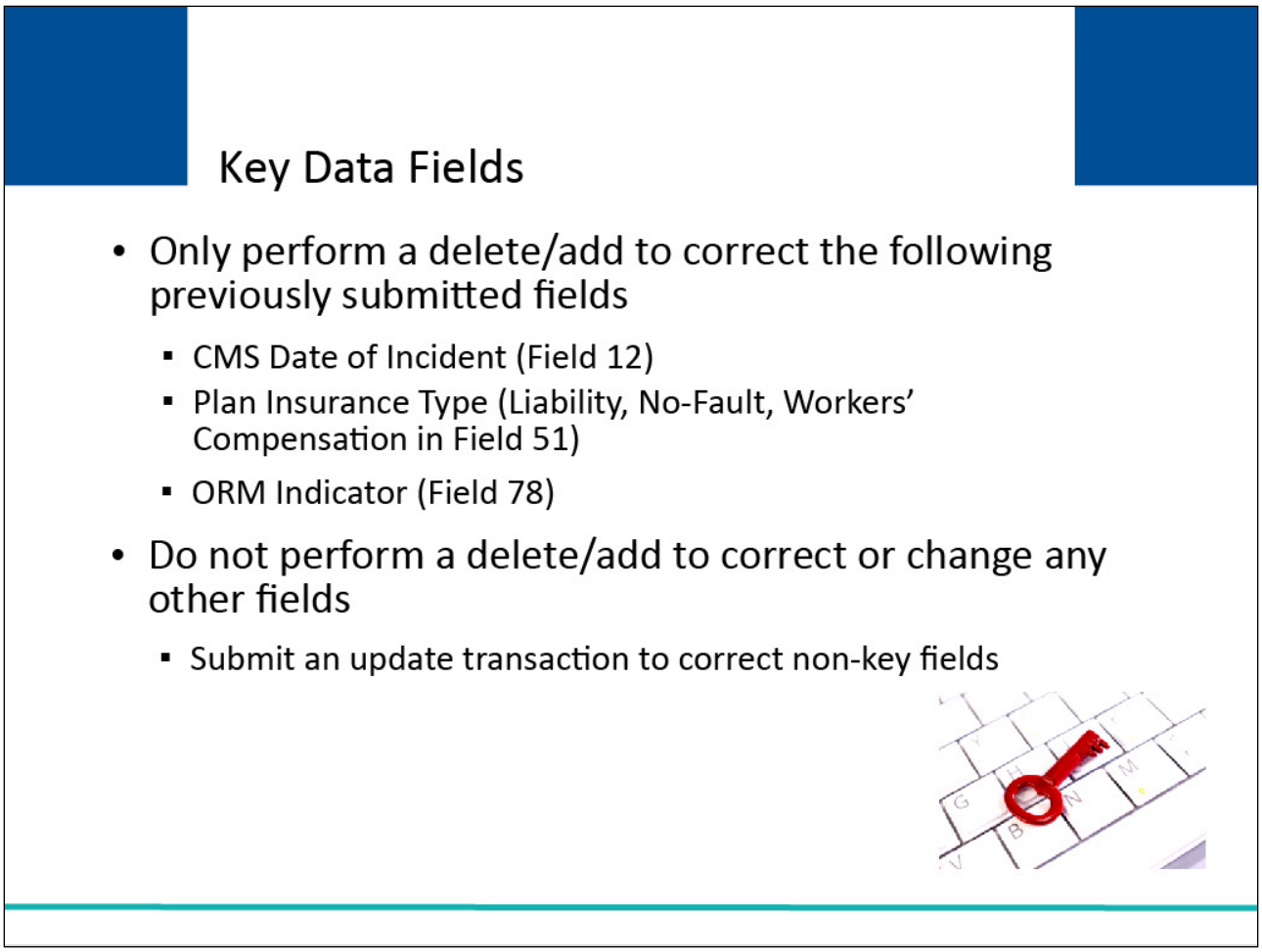
Slide notes

Medicare stores information on claims using key data fields.

If the RRE needs to correct a key field submitted previously, the RRE must send a delete record with the key information that matches the previously accepted add record followed by a new add record with the changed information.

This is often referred to as the “delete/add” process.

Slide 22 of 38 - Key Data Fields



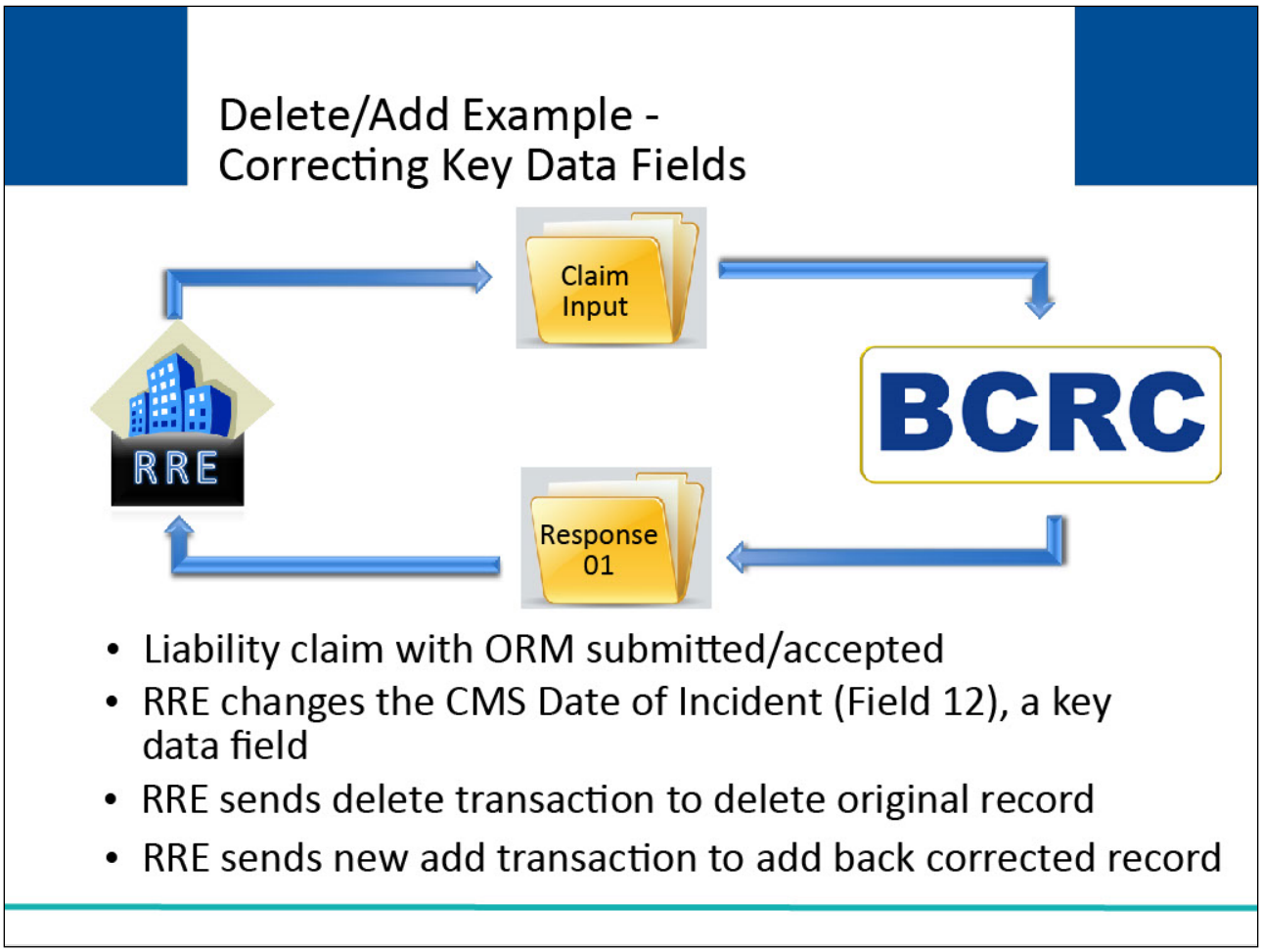
Slide notes

Only perform a delete/add to correct the following previously submitted fields:

- CMS Date of Incident (Field 12)
- Plan Insurance Type (Liability, No-Fault, Workers' Compensation in Field 51)
- ORM Indicator (Field 78)

Do not perform a delete/add to correct or change any other fields. Simply submit an update transaction to correct non-key fields.

Slide 23 of 38 - Delete/Add Example - Correcting Key Data Fields



Slide notes

A Claim Detail Record was submitted for a liability insurance claim with ORM on an RRE's previous quarterly file submission.

It was accepted with a 01 disposition code (i.e., claim accepted and ORM). Subsequently, the RRE changes the CMS Date of Incident (DOI) (Field 12) in its internal system.

Because the CMS Date of Incident (Field 12) is a key data field, the RRE must delete the previously added record and add a new record back with the correct CMS Date of Incident.

On its next Claim Input File, the RRE sends a delete record for the claim.

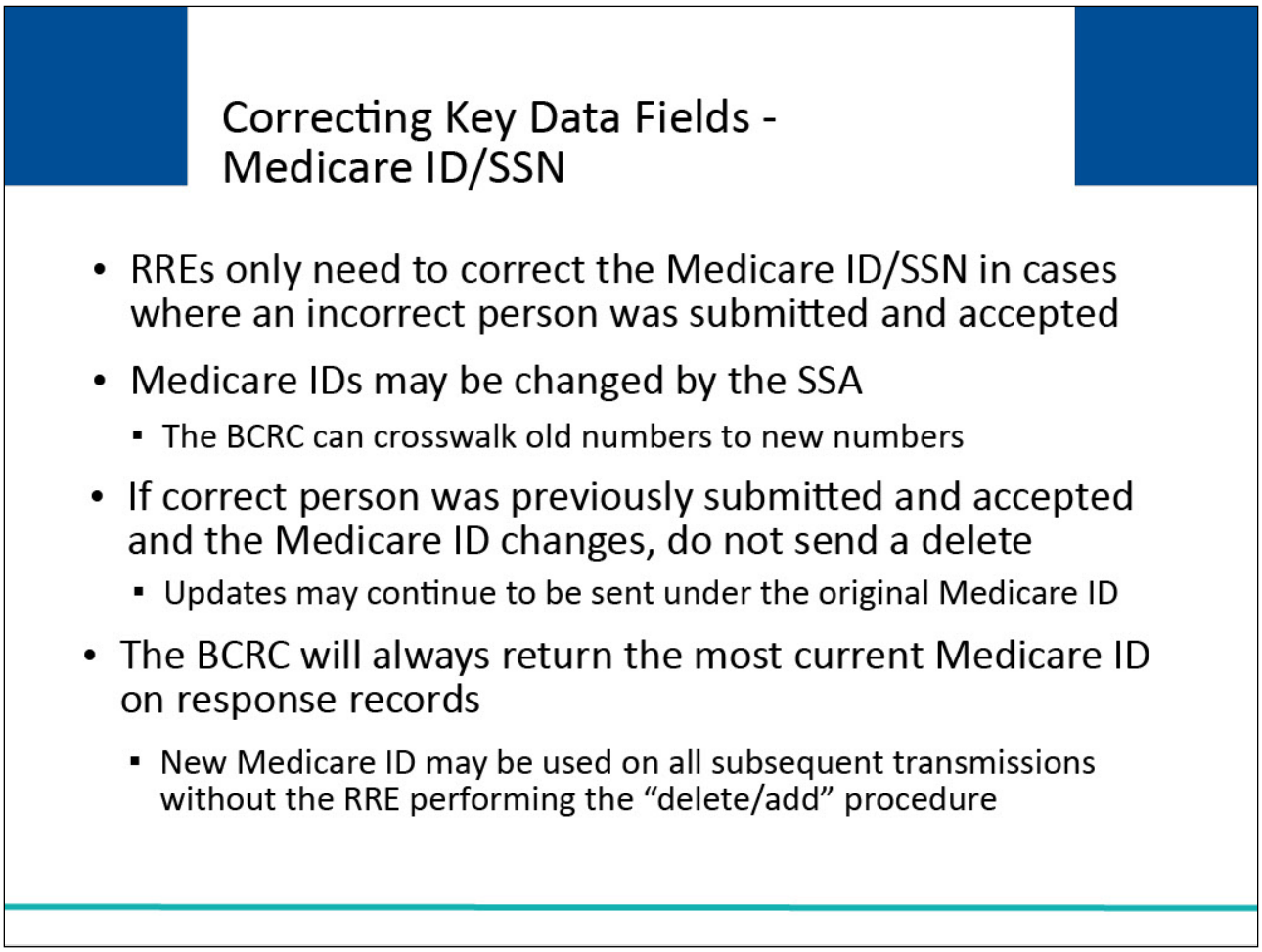
The RRE should submit the most current information they have for the injured party's name, date of birth, and gender, all other claim information they previously submitted in the key fields on the original record and place a 1 in the Action Type Field.

In the same Claim Input File, the RRE sends an add record for the claim with the changed information, including the new CMS Date of Incident, a 0 in the Action Type Field, and all other required data elements.

The BCRC processes both records and returns a record for each on the response file with the applicable disposition code.

The original record will be deleted from the BCRC system and the new add record will be added back with the corrected CMS Date of Incident.

Slide 24 of 38 - Correcting Key Data Fields - Medicare ID/SSN



Slide notes

RREs only need to correct the Medicare ID/SSN in cases where an incorrect person was submitted and accepted on the input record.

Medicare IDs may be changed by the Social Security Administration (SSA) at times but, the BCRC is able to crosswalk the old numbers to the new numbers.

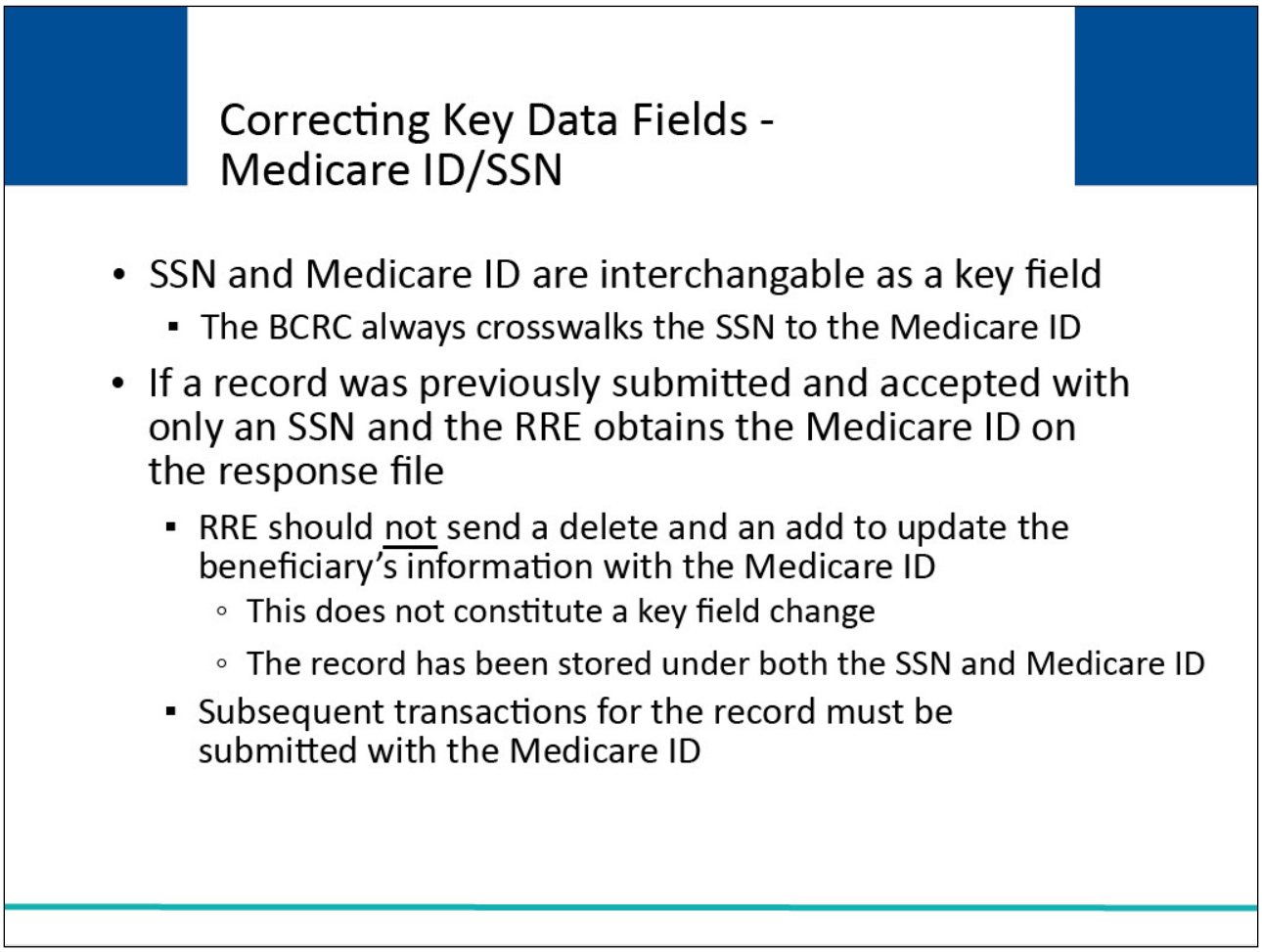
Therefore, in those instances where the correct person was previously submitted and accepted and the Medicare ID changes for that person at a later date, the RRE should not send a delete to correct the record.

In fact, updates may continue to be sent under the original Medicare ID submitted.

The BCRC will always return the most current Medicare ID on response records and RREs are encouraged to update their systems with that information and use it on subsequent record transmissions.

The new Medicare ID may be used on all subsequent transactions without the RRE performing the “delete/add” procedure.

Slide 25 of 38 - Correcting Key Data Fields - Medicare ID/SSN



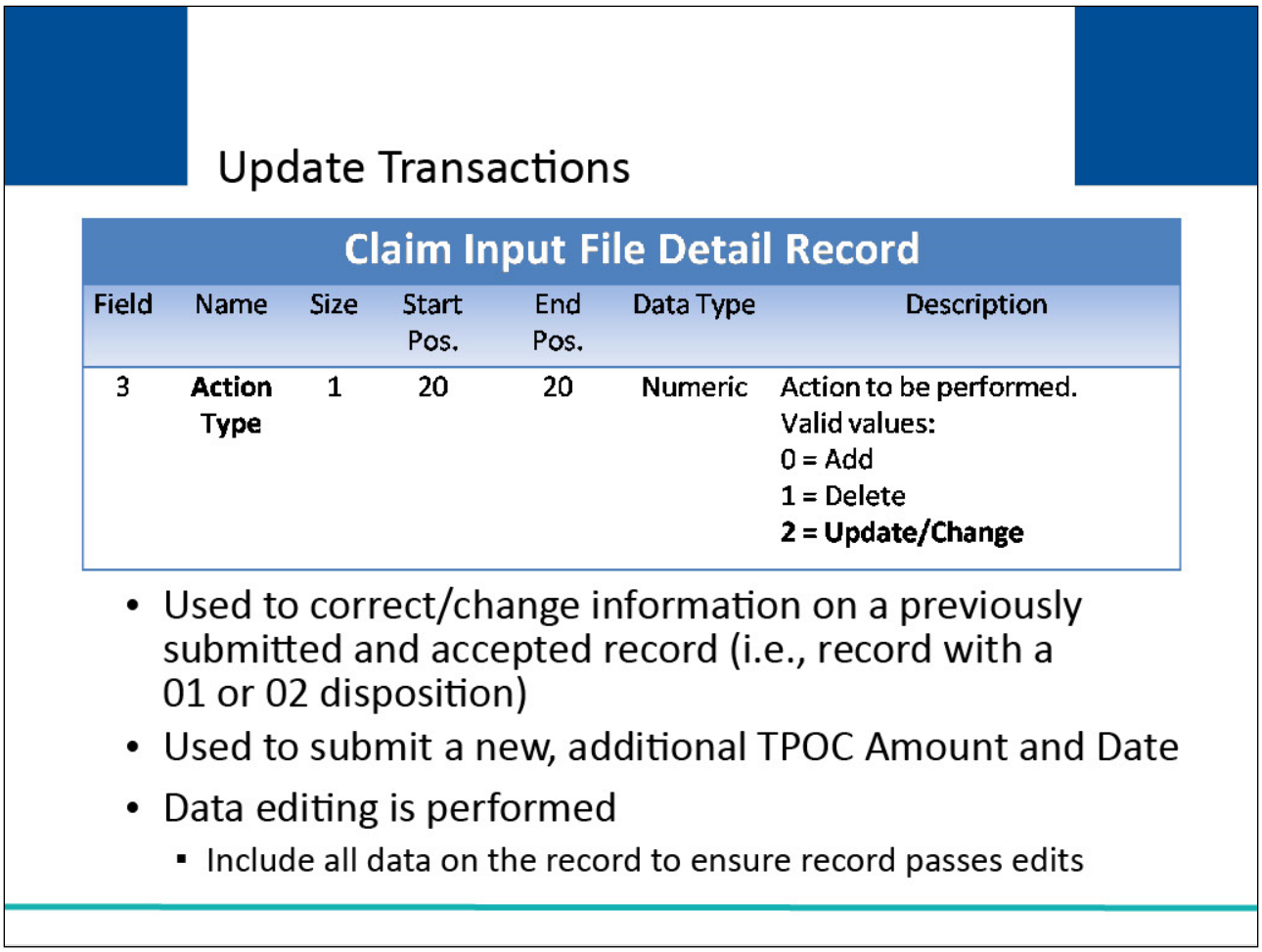
Slide notes

Also note that the SSN and Medicare ID are interchangeable as a key field for a record and the BCRC always crosswalks the SSN to the Medicare ID for records submitted without a Medicare ID.

If a record was previously submitted and accepted with only an SSN and the RRE obtains the Medicare ID on the response file, the RRE should not send a delete and an add to update the beneficiary's information with the Medicare ID.

This does not constitute a key field change. The record has already been stored under both the SSN and Medicare ID by the BCRC. Subsequent transactions for the record must be submitted with the Medicare ID.

Slide 26 of 38 - Update Transactions



Slide notes

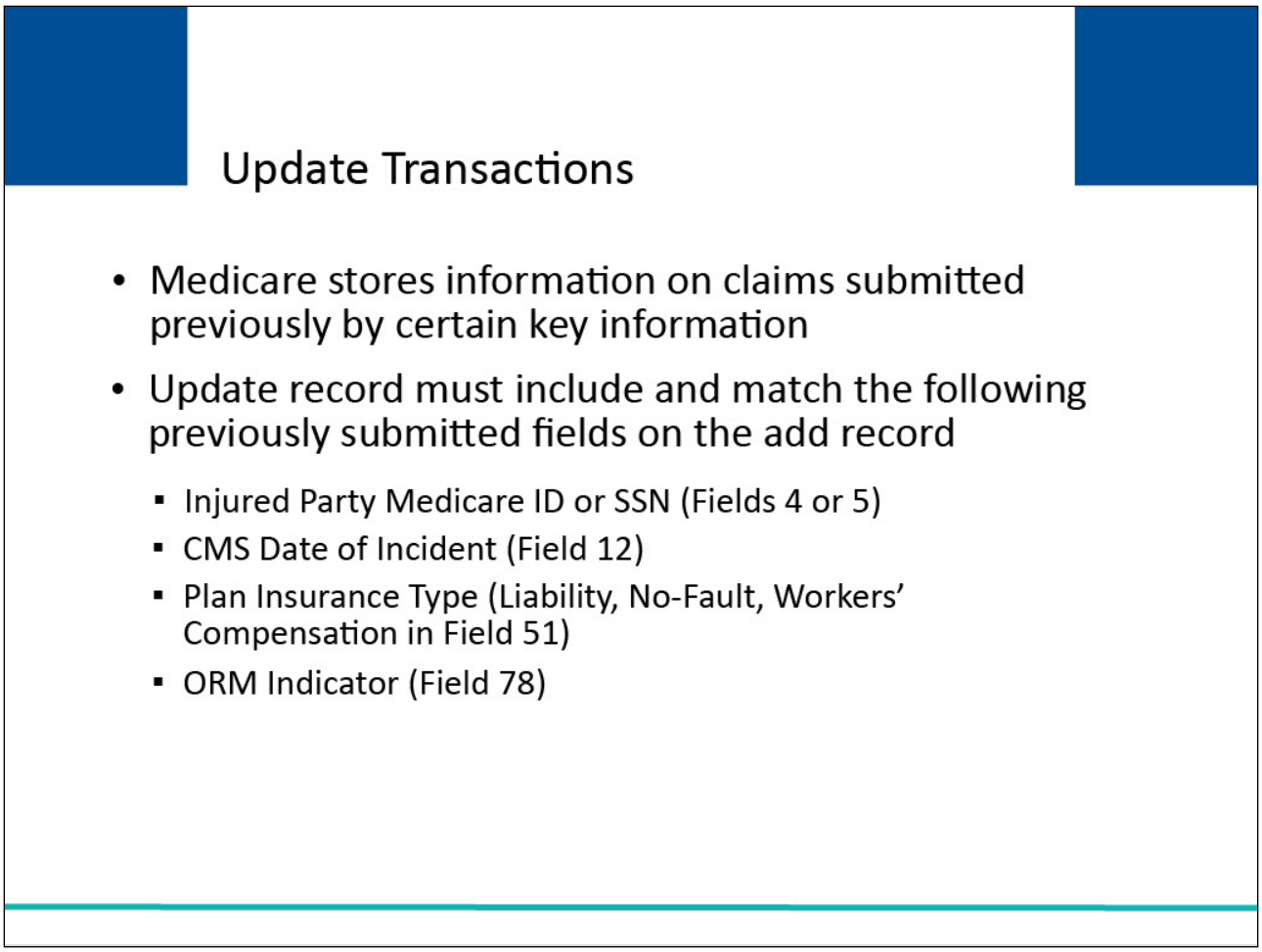
An update record or transaction is defined with a 2 in the Action Type (Field 3).

An update transaction with an Action Type of 2 is sent when you need to change information on a record previously submitted and accepted by the BCRC, for which you received a 01 or 02 disposition code in your Claim Response File.

An update transaction is also sent when you need to submit a new, additional TPOC Amount and Date. Data editing is performed on updated transactions to ensure that the information provided is accurate, complete, and consistent.

Ensure that all data is included on the record to ensure the record passes data edits. Refer to the NGHP User Guide and the Claim Input File Data Elements course for additional information on data editing.

Slide 27 of 38 - Update Transactions

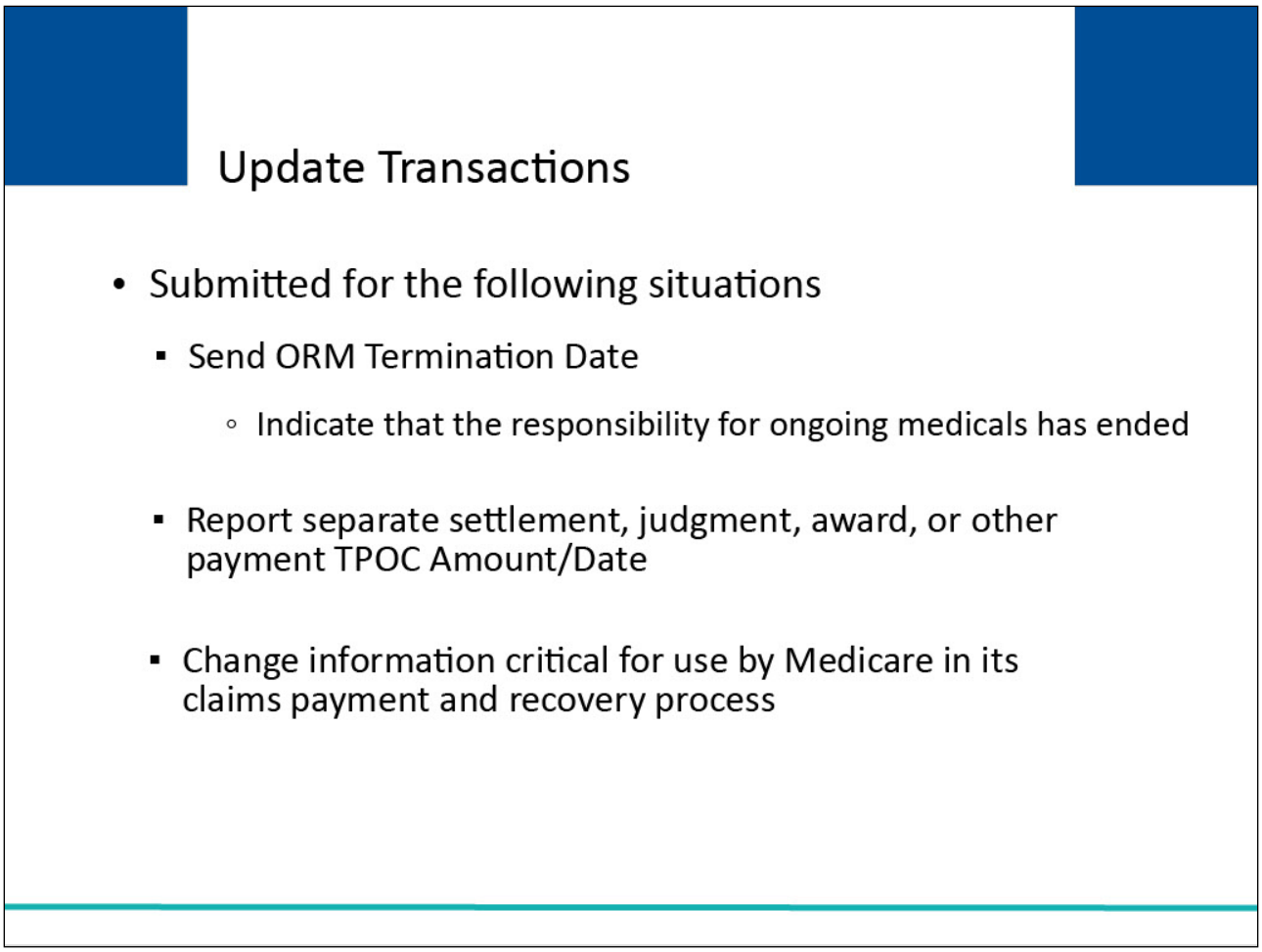


Slide notes

Because Medicare stores information on claims submitted previously by certain key information, the following fields on an update record must match the add record sent previously in order for the update to be successful:

- Injured Party Medicare ID or SSN (Fields 4 or 5)
- CMS Date of Incident (Field 12)
- Plan Insurance Type (Liability, No-Fault, Workers' Compensation in Field 51)
- ORM Indicator (Field 78)

Slide 28 of 38 - Update Transactions



Slide notes

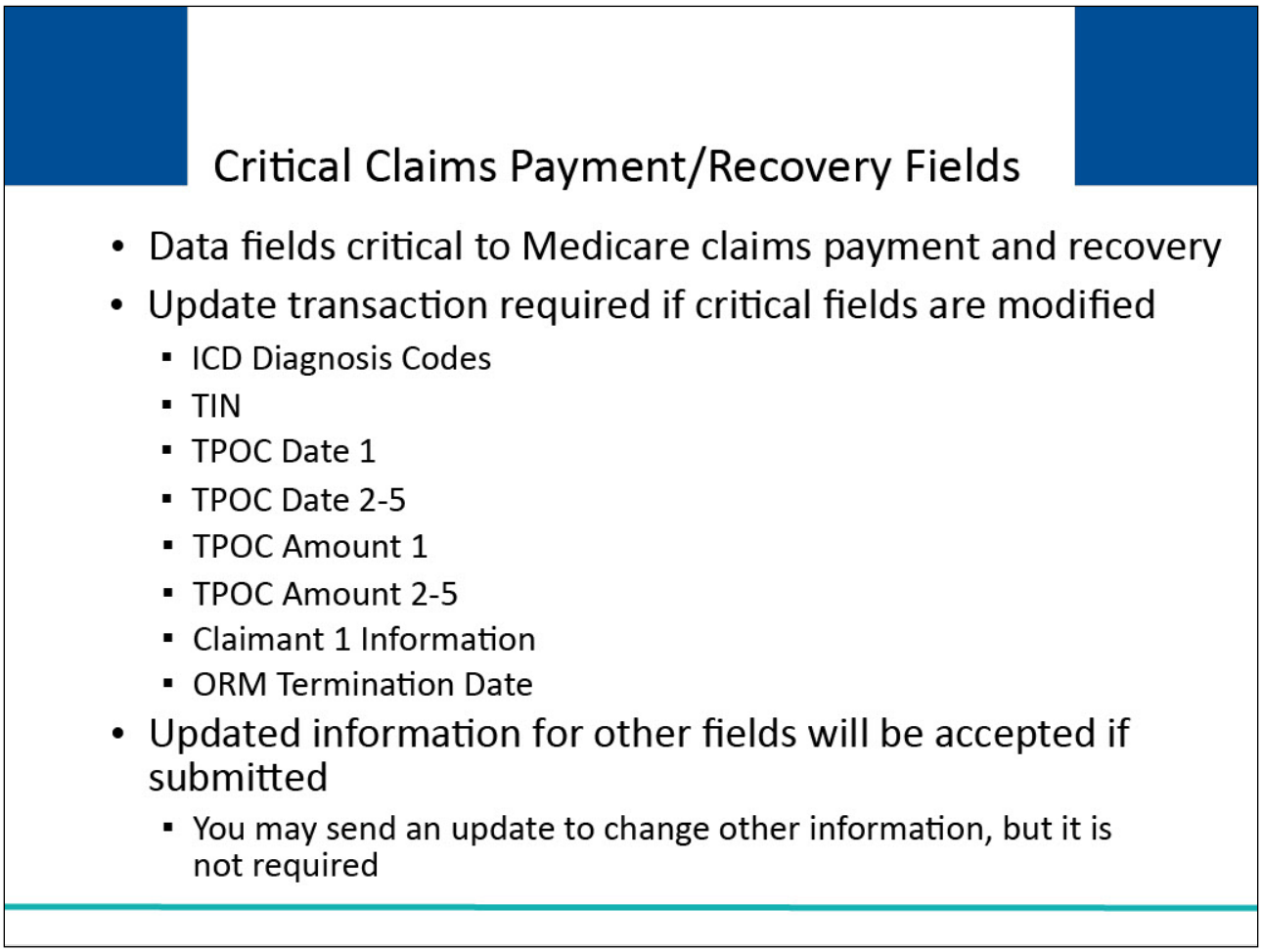
Update records are submitted under three circumstances.

The first is when an RRE needs to send the ORM Termination Date to indicate that the responsibility for ongoing medicals has ended (this may be a simple termination, or it might be associated with the reporting of a settlement, judgment, award, or other payment TPOC Amount and Date).

The second is when a report of ongoing responsibility for medicals has already been submitted and accepted and there is a separate settlement, judgment, award, or other payment TPOC Amount and Date but the RRE continues to retain ongoing responsibility for medicals. The third circumstance is to change information critical for use by Medicare in its claims payment and recovery processes.

See the Event Table for additional information.

Slide 29 of 38 - Critical Claims Payment/Recovery Fields



Slide notes

Certain data fields on the Claim Input File are critical for use by Medicare in its claims payment and recovery process.

If the RRE changes information in one or more of the following critical data fields, they must send the modified information in an update transaction on their next quarterly claim submission:

ICD Diagnosis Codes 1-19 (beginning in Field 18 of the Detail Record) - This is the ICD-9/ICD-10 (International Classification of Diseases, Ninth/Tenth Revision, Clinical Modification) Diagnosis Code describing the alleged injury/illness.

Note: ICD-10 Diagnosis Codes will be accepted on claim reports starting October 1, 2015;

- TIN (Field 52 of the detail record)
- TPOC Date 1 (Field 80, of the detail record)
- TPOC Date 2-5 (Fields 93, 96, 99, and 102 of the auxiliary record)
- TPOC Amount 1 (Field 81 of the detail record)
- TPOC Amount 2-5 (Fields 94, 97, 100 and, 103 of the auxiliary record)
- Claimant 1 Information (Fields 84-95 of the detail record)

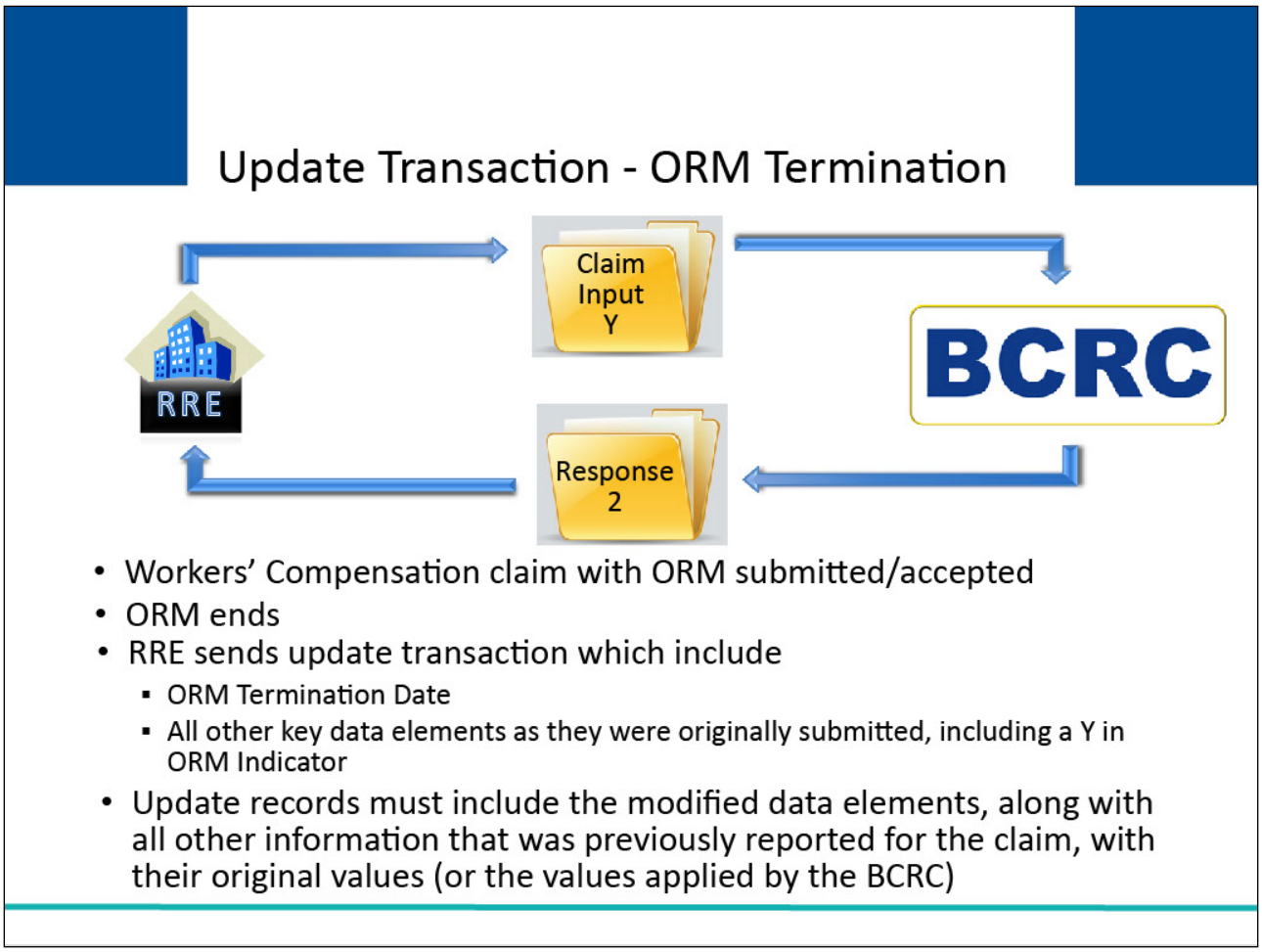
- ORM Termination Date (Field 79 of the detail record)

Additionally, an excel spreadsheet of the ICD-9/ICD-10 excluded and valid codes for FY 2023 are now available for download on CMS.gov at CMS ICD-9-ICD-10 Codes

Note: Updated information for other fields will be accepted if submitted but changes to other fields do not trigger the update requirement. You may send an update to change other information but it is not required. To support previous system changes, Policy Number (Field 54) has been added as a key field. If this field changes, RREs must submit a delete Claim Input File record that matches the previously accepted add record, followed by a new add record with the changed information (i.e., delete/add process).

Following are examples to enhance your understanding of how to submit Claim Input File Detail update transactions.

Slide 30 of 38 - Update Transaction - ORM Termination



Slide notes

A Claim Detail Record was previously submitted by an RRE and accepted by the BCRC for a Workers' Compensation claim where the RRE assumed ORM (the ORM Indicator Field 78 was submitted with a Y).

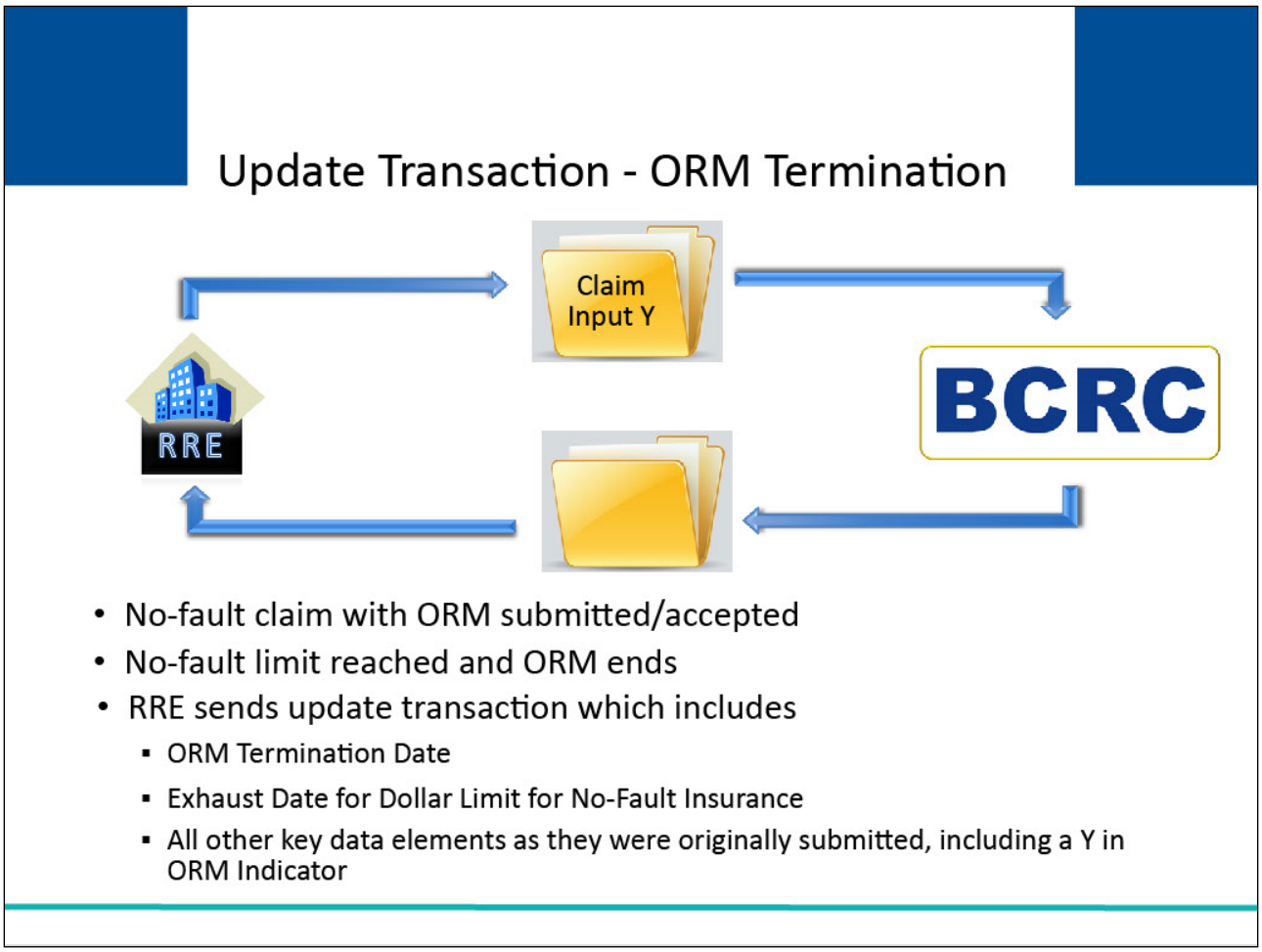
The RRE's ongoing responsibility has since ended, the injured party/Medicare beneficiary's injury is healed, and they have returned to work.

In the next quarterly Claim Input File submission, the RRE sends an update record for the previously accepted Claim Input File Detail Record with a 2 in the Action Type (Field 3), and the ORM Termination Date (Field 79), reflecting when the RRE's ongoing responsibility ended and the Claim Detail Record was closed. All other key data elements should match the original submission for this Claim Input File Detail Record, including a Y in the ORM Indicator.

When the RRE sends an update record, they must include the modified data elements, along with all other information that was previously reported for the claim, with their original values (or the values applied by the BCRC).

Note that an update record is sent to report the ORM Termination Date, not a delete transaction. Also note that the ORM Indicator should continue to be reported with a value of 'Y' on the update record.

Slide 31 of 38 - Update Transaction - ORM Termination



Slide notes

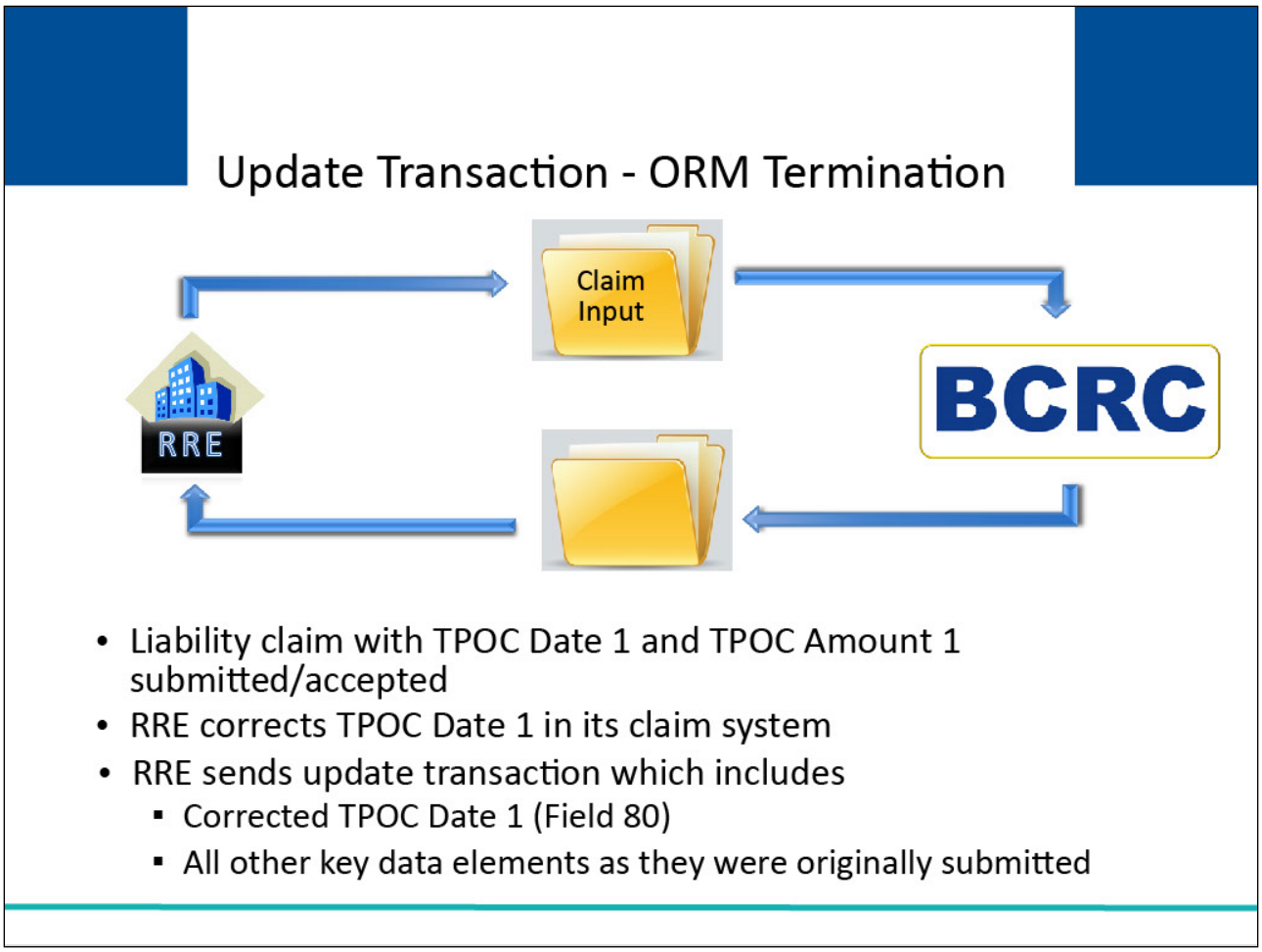
A Claim Detail Record was previously submitted by an RRE and accepted by the BCRC for a no-fault claim where the RRE assumed ORM (the ORM Indicator Field 78 was submitted with a Y).

The limit on the no-fault portion of the policy applicable to the claim was provided in the No-Fault Insurance Limit (Field 61). Subsequently, the no-fault limit was reached and the RRE's ORM ended.

In the next quarterly Claim Input File submission, the RRE sends an update record for the claim with a 2 in the Action Type (Field 3), an ORM Termination Date (Field 79), reflecting when the RRE's ORM ended, and the date the no-fault limit was reached in the Exhaust Date for Dollar Limit for No-Fault Insurance (Field 62).

All other key data elements are submitted as they were on the original report, including a Y in the ORM Indicator.

Slide 32 of 38 - Update Transaction - ORM Termination



Slide notes

A Claim Detail Record was previously submitted by an RRE and accepted by the BCRC for a liability claim with a settlement, judgment, award, or other payment information in TPOC Date 1 (Field 80) and TPOC Amount 1 (Field 81).

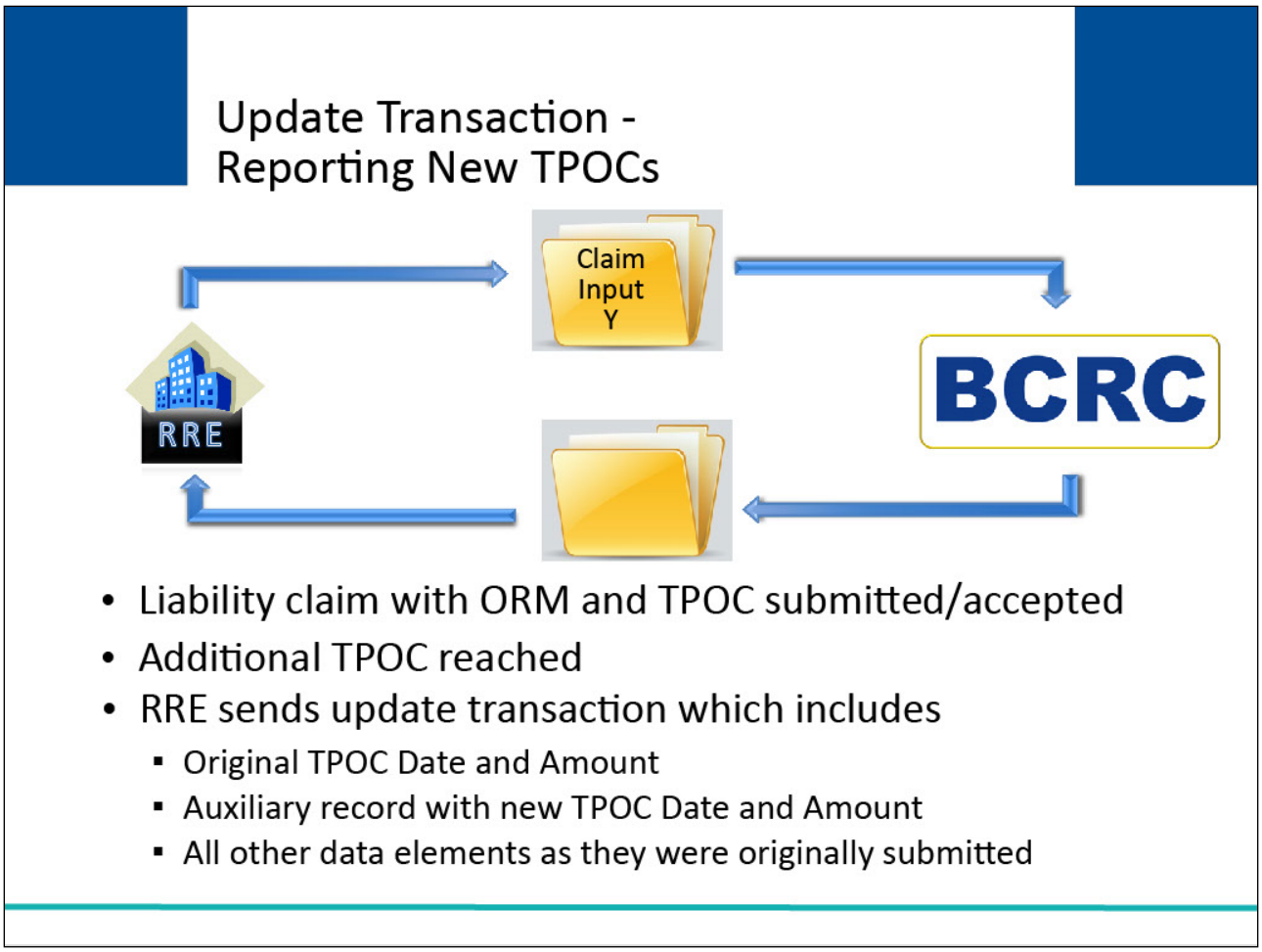
Subsequently, the RRE corrects the TPOC Date 1 (Field 80) in its claim system since an incorrect date was entered initially.

In the next quarterly Claim Input File submission, the RRE sends an update record for the previously accepted Claim Input File Detail Record with a 2 in the Action Type (Field 3), and the corrected TPOC Date 1 (Field 80).

All other key data elements should match the original submission for this Claim Input File Detail Record.

Note: For liability claims, it is now optional to report ‘NOINJ’ codes in certain circumstances (NGHP User Guide, Section 6.2.5.2)

Slide 33 of 38 - Update Transaction - Reporting New TPOCs



Slide notes

Claim Detail Record was previously submitted by the RRE and accepted by the BCRC for a liability insurance claim with a settlement, judgment, award, or other payment TPOC.

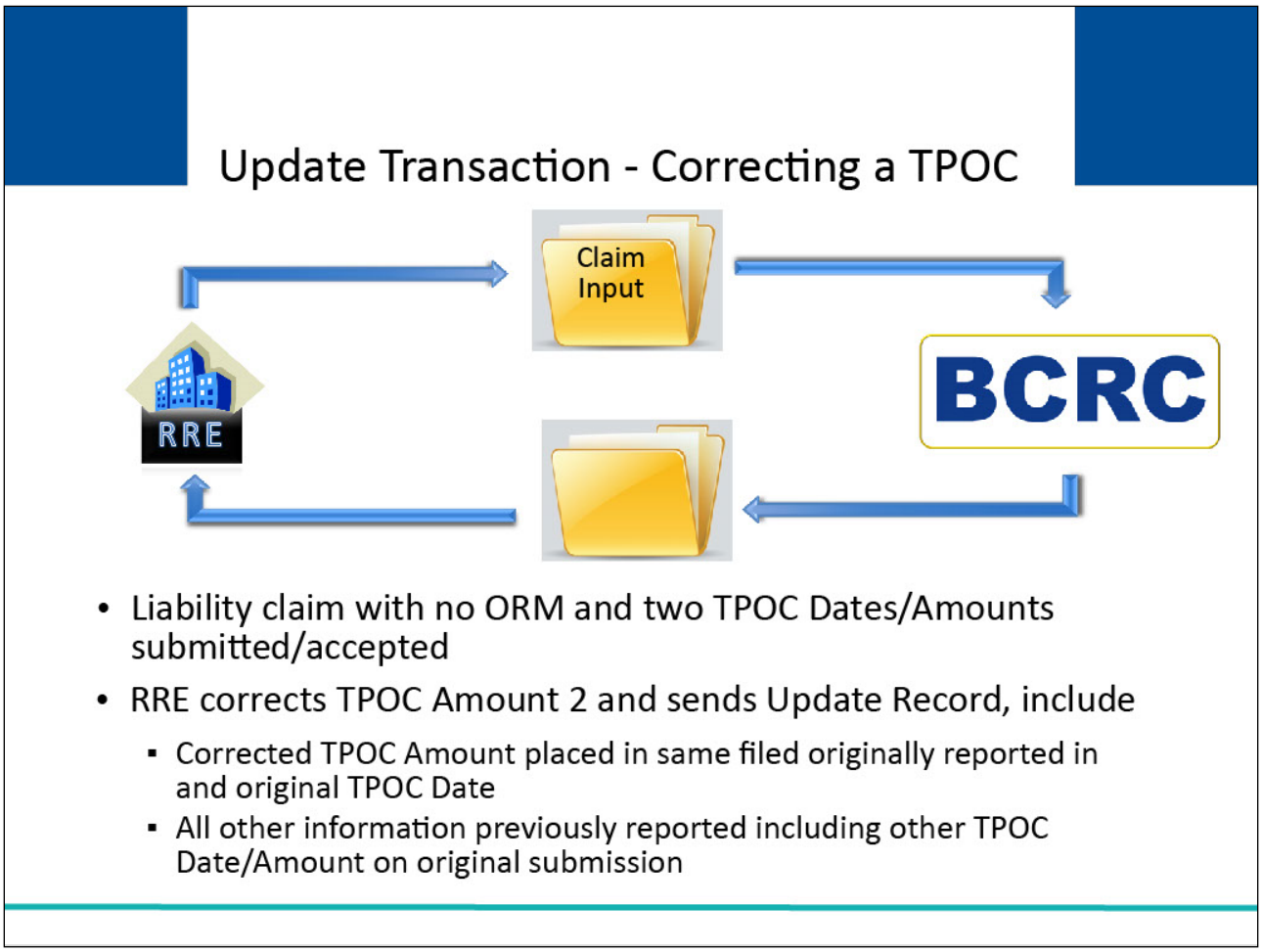
The Claim Detail Record submitted reflected ORM (ORM Indicator = Y) and included a TPOC Date 1 and TPOC Amount 1 (Fields 80 and 81).

Subsequently, an additional settlement, judgment, award, or other payment (including the assumption of ORM) TPOC is reached with respect to the same Claim Detail Record.

In the next quarterly Claim Input File submission, the RRE sends an Update Record for the claim with a 2 in the Action Type (Field 3) of the Detail Record, places the previously reported TPOC Date 1 and TPOC Amount 1 in Fields 80 and 81 of the detail record, and places the new, additional TPOC Date and TPOC Amount in TPOC Date 2 and TPOC Amount 2 (Fields 93 and 94) on the auxiliary record immediately following the Detail Record.

All other data elements are submitted as they were on the original report, including a Y in the ORM Indicator on the Detail Record.

Slide 34 of 38 - Update Transaction - Correcting a TPOC



Slide notes

A Claim Detail Record was previously submitted by the RRE and accepted by the BCRC for a liability insurance claim with no ORM. The original submitted Claim Detail Record was reported with two TPOCs.

The first was submitted in the TPOC Date 1 and TPOC Amount 1 (Fields 80 and 81). The second was reported on the auxiliary record in the TPOC Date 2 and TPOC Amount 2 (Fields 93 and 94). Subsequently, it is determined that the amount originally entered on the auxiliary record was incorrect.

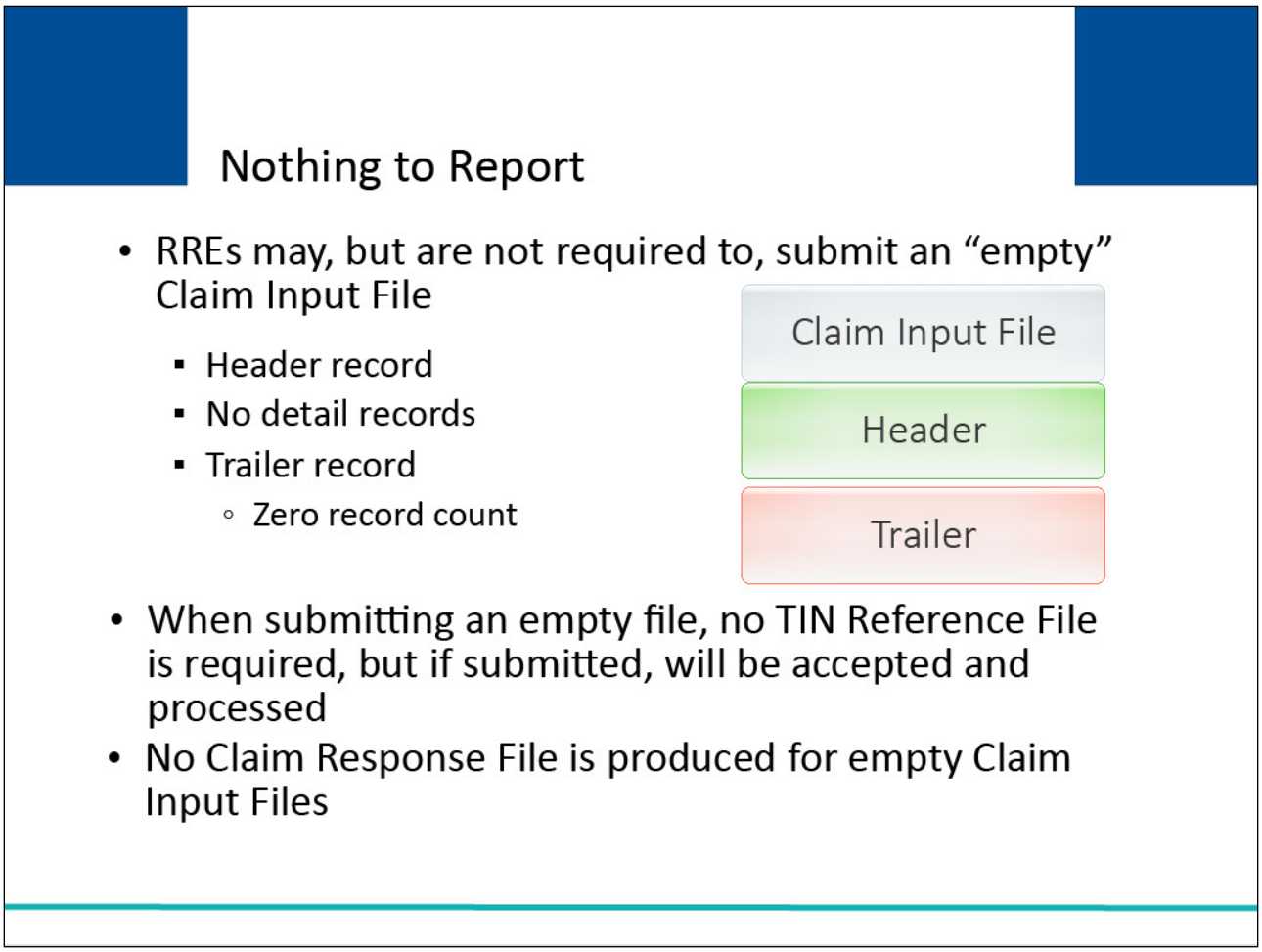
In the next quarterly Claim Input File submission, the RRE sends an update record for this claim with a 2 in the Action Type (Field 3) of the Detail Record.

The corrected TPOC Amount must be placed in the same field it was reported in previously (in this example, it would be placed in Field 94 of the auxiliary record).

Although the TPOC Date 2 was correct on the original submission, it must be reported with its original value in the same field it was reported in previously (Field 93).

All other information that was previously reported for this claim, including the other TPOC Date and TPOC Amount, should be reported with their original values (or the values applied by the BCRC).

Slide 35 of 38 - Nothing to Report

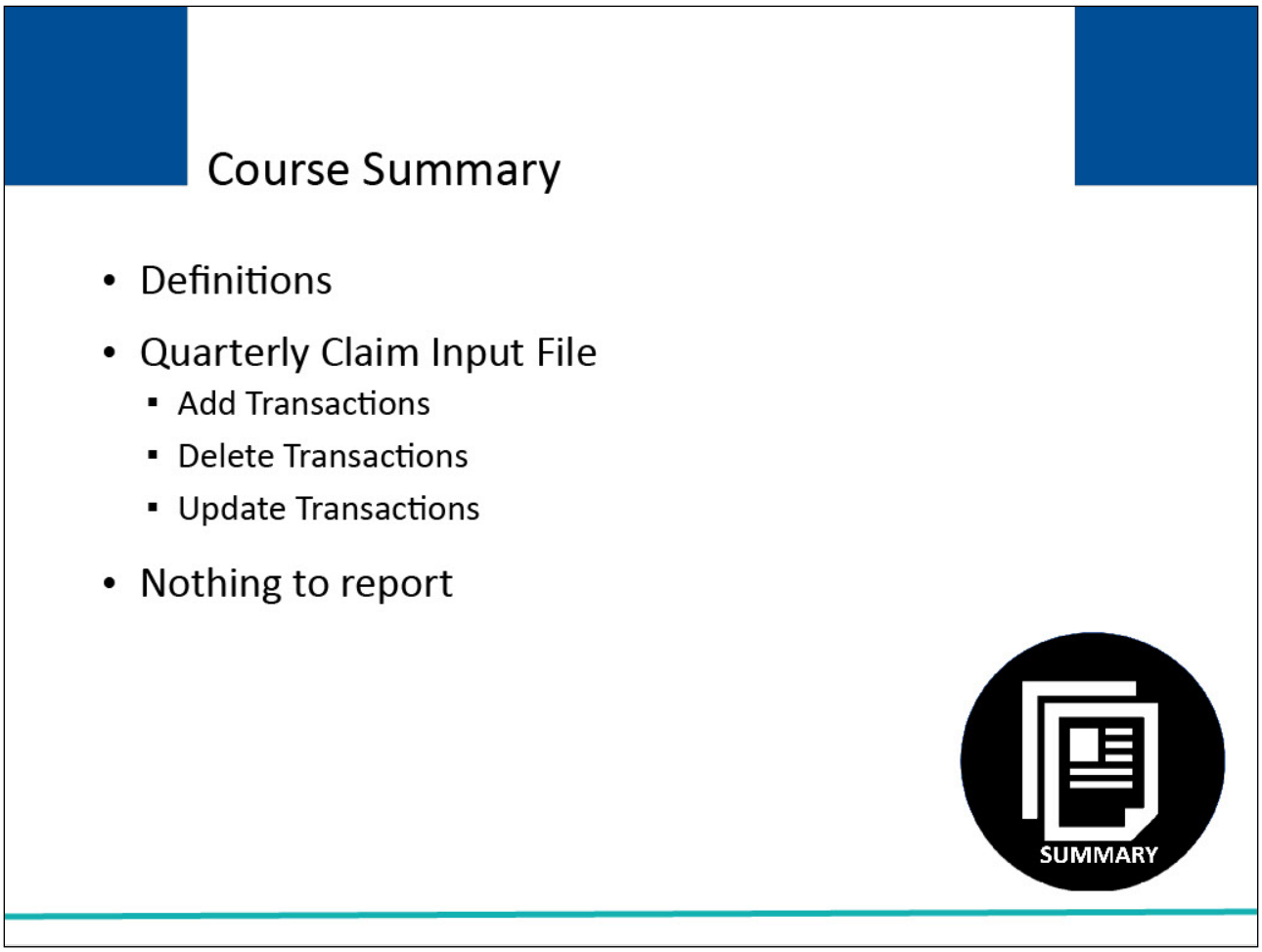


Slide notes

If you have no new information to supply on a quarterly update file, you may, but are not required to, submit an “empty” Claim Input File with a header record, no detail records, and a trailer record that indicates a zero detail record count.

When submitting an empty file, no TIN Reference File is required, but if submitted, will be accepted and processed. No Claim Response File is produced for empty Claim Input Files.

Slide 36 of 38 - Course Summary



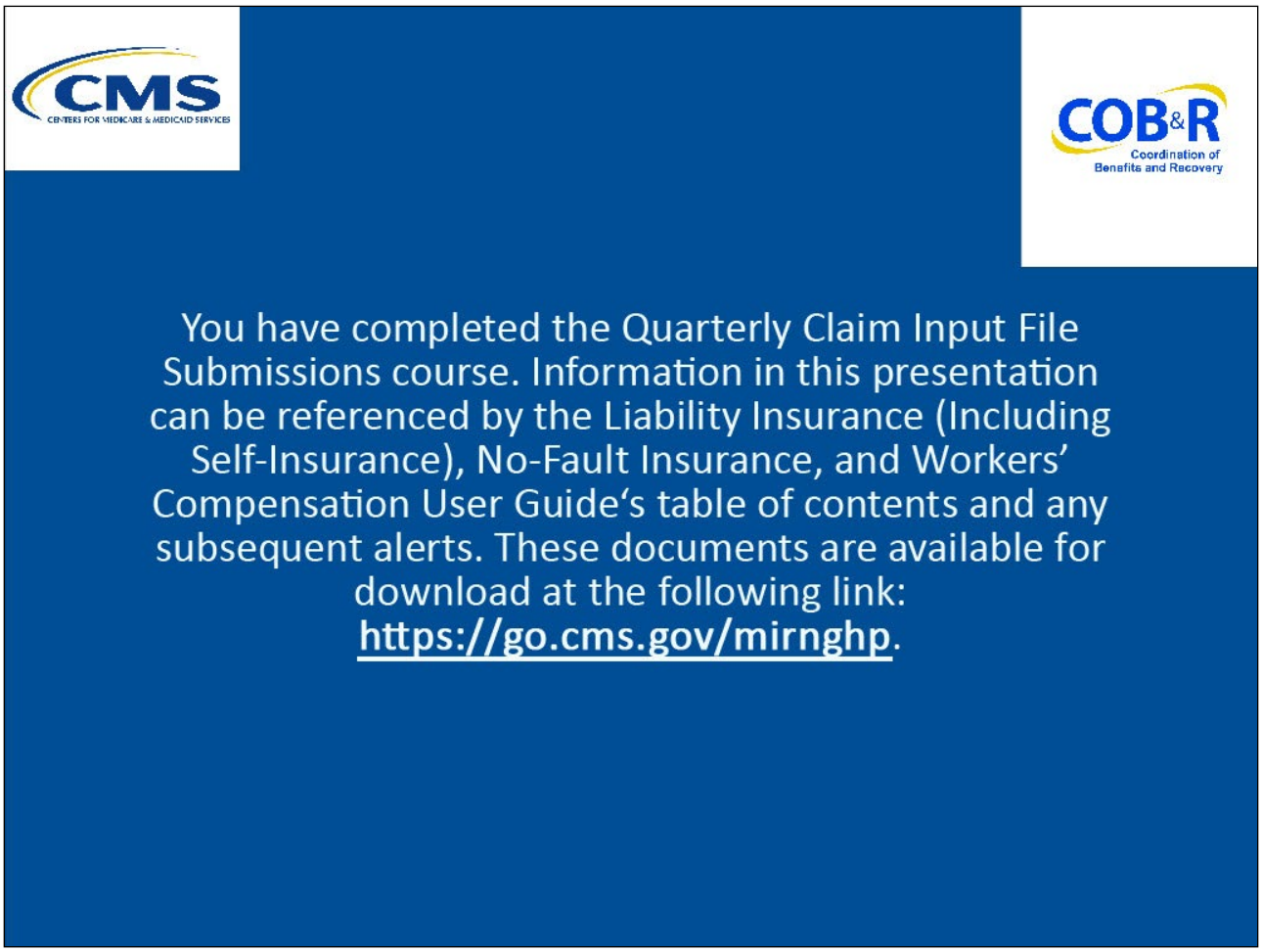
Slide notes

You should now be able to discuss the terminology used in this CBT and explain what is to be reported on the quarterly Claim Input File.

It described the add, delete, and update transactions and when you would use each, and explained what to do when you don't have any Claim Detail Records or changes to report.

Important: Although information in this CBT pertains to the creation of the electronic Claim Input File, DDE submitters must adhere to essentially the same Section 111 reporting requirements and are also required to submit the same data on the Section 111 Coordination of Benefits Secure Website (COBSW).

Slide 37 of 38 - Conclusion

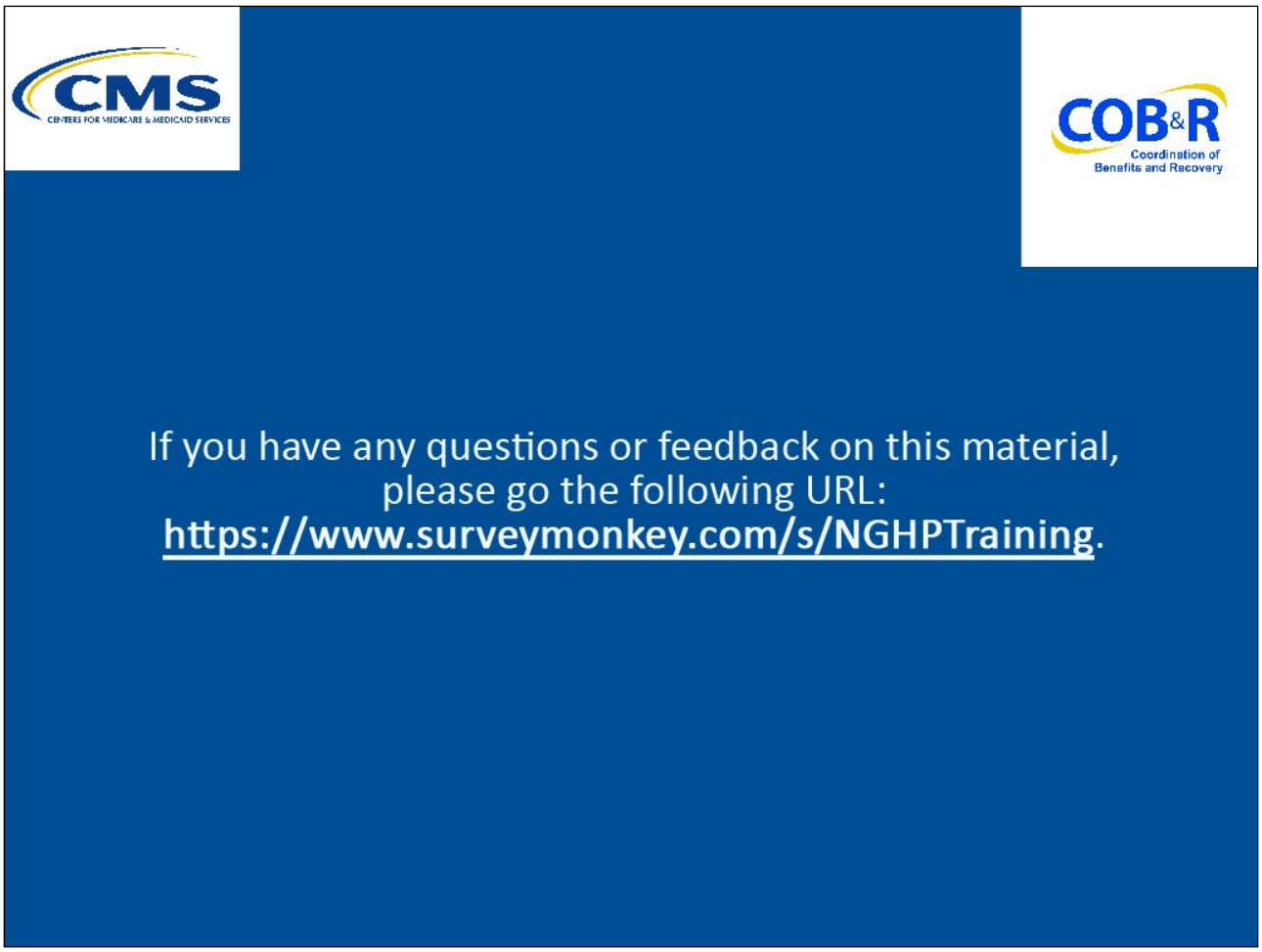


Slide notes

You have completed the Quarterly Claim Input File Submissions course. Information in this presentation can be referenced by the Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation User Guide's table of contents and any subsequent alerts.

These documents are available for download at the following link: CMS NGHP Website.

Slide 38 of 38 - NGHP Training Survey



Slide notes

If you have any questions or feedback on this material, please go the following URL: Training Survey.